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Report of the
TASK GROUP ON HOMES FOR SPECIAL CARE

to the
Minister of Social Services

Nova Scotia

Department of
Social Services

Honourable Edmund L. Morris
Minister

TASK GROUP REPORT

TO THE

MINISTER OF SOCIAL SERVICES

ON

HOMES FOR SPECIAL CARE

June, 1984

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Special mention must be made of the representatives of the Departments of Education and Health, the Union of Nova Scotia Municipalities and individual municipalities, the Associated Homes for Special Care and individual Homes, and the Nova Scotia Federation of Labour, who devoted considerable time and made invaluable contributions to the various working groups.

Several members of the Task Group and the Working Groups were able to visit and view first hand the service, programs and facilities in other provinces. To our colleagues in the Departments of Community and Social Services and the Departments of Health in the provinces of Alberta, Manitoba, Ontario, New Brunswick, and Prince Edward Island, we extend our appreciation for their courtesy and assistance. We also wish to thank the administrators, staff and residents of the facilities visited for sharing their experience and ideas with us. In addition the Task Force is grateful to the staff of the various government departments whom we contacted in other provinces and who responded with written material.

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INTRODUCTION

The Task Group on Homes for Special Care was established by the Honourable Edmund L. Morris, Minister of Social Services, in February 1983. Initially the Task Group was mandated to examine Nursing Homes, Homes for the Aged and Residential Care Facilities. Later the mandate was twice expanded, in April 1983 programs for the mentally handicapped were included and in June 1983 comforts allowance was added. Terms of Reference for all three areas are contained in Appendix A.

The Task Group consisted of a core committee of senior staff of the Department of Social Services. Seven sub-committees known as Working Groups were formed to carry out various tasks related to the mandate. These sub-committees were chaired by persons from the Department's senior staff. They included representatives of non-governmental bodies (such as the Union of Nova Scotia Municipalities, the Nova Scotia Federation of Labour and the Associated Homes for Special Care) and of the two government departments which have a direct relationship with Social Services, the Departments of Education and Health. Members of the Task Group and the Working Groups are listed in Appendix B.

In pursuing its mandate, the members of the Task Group and the Working Groups explored several avenues and sources of information. The Task Group held a series of meetings throughout the province with representatives of municipalities, Homes for Special Care, community organizations and agencies, and interested federal and provincial government departments such as Canada Mortgage and Housing and the Departments of Housing and Health. On occasion private individuals requested meetings with the Task Group and these were arranged. Individual Working Groups also met with representatives, staff and residents of Homes for Special Care, municipalities, community organizations and hospitals in the course of examining their specific areas of concern. On a number of occasions members of Working Groups also attended meetings held by the Task Group. A list of the meetings held and Briefs received can be found in Appendices C and D.

Advertisements soliciting the comments and concerns of the general public were placed in all daily and weekly newspapers in the province. The number of responses received was not substantial but the comments were thought provoking.

A search of the relevant literature was made, and information about services and programs in other provinces was obtained by letter, telephone calls and personal visits. Surveys of staff and residents of Homes for Special Care in Nova Scotia were also carried out on specific subject areas by several of the Working Groups.

The Working Groups compiled background papers which were received by the Task Group between November 1983 and May 31, 1984. Each Working Group Report was reviewed by the Task Group and meetings held with the individual chairperson.

The Task Group Report which is presented here reflects the documents prepared by the Working Groups. It has been augmented by the Task Group's own experience and perspective on the issues and concerns. Comments have been added where information gaps existed and where particular areas were not addressed by Working Groups.

The body of this report is divided into eight sections, most of which deal primarily with matters related to the elderly. The sections on Services to Mentally Handicapped Children and Services to Mentally Handicapped Adults are separate due to the distinctions in the populations served and in programming needs.

The central theme of this report is that the needs of each individual, regardless of age, infirmity, disability or handicap, must be the paramount concern of all levels of government and the private sector in maintaining, enhancing and expanding programs and services. Furthermore, regardless of whether the services are provided in institution, home, or community, a quality and standard of care must be maintained which enriches the lives of the people served.

The Task Group agrees with the proponents of community services and community based care alternatives that the preferred care option for most people, whether

adults or children with special needs, is maintenance in their own homes and communities in a non-institutional setting. However, for that small group of individuals whose needs go beyond what is or can be provided through in-home support services, Homes for Special Care ranging from small community-based facilities to larger institutions offer a viable and necessary alternative. Such facilities must be seen as a vital and necessary part of a total care system.

This report seeks to address some of the issues, questions and concerns related to the care of those Nova Scotians who now reside in Homes for Special Care, and to look beyond 1984 to the next decade.

GLOSSARY

These definitions are based on common usage, not necessarily on legal terminology.

ADULT RESIDENTIAL CENTRES	These are facilities which provide rehabilitation training and developmental programming for persons who are mentally handicapped, in particular those who require more stable, longer term living environments.
CHILDREN'S TRAINING CENTRES	Four regional residential centres are operated by the Department of Social Services for severely mentally handicapped children who require physical care and will respond to developmental training.
COMFORTS ALLOWANCE	This is an allowance which is provided by municipalities to publicly assisted residents in a Home For Special Care and which may be used to purchase personal items such as magazines, newspapers and cosmetics.
COMMUNITY-BASED RESIDENTIAL FACILITY	This term refers to any building or place where persons receive supervisory care in a residential and family environment, where the care is provided by persons who are not their parents. The term includes group homes for persons who require training to enable them to reach their maximum degree of independence and self-sufficiency, and developmental residences for severely handicapped individuals who require training to become self-sufficient in daily living.
DAY CARE FOR SENIORS	This is a program which is operated within a Home for Special Care and allows seniors who reside in the community to participate in supervised activities in the Home during the day time hours.
DEVELOPMENTAL RESIDENCES	These are facilities which accommodate approximately eight residents and which provide intensive life skills, community orientation and training for severely mentally handicapped adults.

GROUP HOMES

These are training facilities which provide assistance in the development of social skills, basic community living skills and general adaptation to community life for mentally handicapped persons.

HOME FOR SPECIAL CARE

Means a Nursing Home, a Home for the Aged, Adult Residential Centre, Regional Rehabilitation Centre or a Residential Care Facility. The term residential care facility includes community residential facilities such as group homes and developmental residences.

HOME LIFE SUPPORTS

Refers to the provincial initiatives which expanded the traditional homemaker services program, established a provincial demonstration fund, and established a municipal cost-shared program, to enhance in-home support services to assist elderly and disabled persons who wish and are able to remain independent in their own homes.

LEVELS OF CARE

Level I

The care required by a person who is ambulant and/or independently mobile, and who primarily requires supervision and/or assistance with activities of daily living.

Level II

The care required by a person with a relatively stabilized chronic disease or functional disability, whose condition is not likely to change in the near future and who requires the availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision.

Level III

The care required by a person who is chronically ill and/or has a functional disability, where the acute phase of illness is over, the vital processes stabilized, and where the potential for rehabilitation may be limited. This person requires a range of therapeutic services, medical management and skilled nursing care.

NORMALIZATION	Means making available to the mentally handicapped patterns and conditions of every day life which are as close as possible to the norms and patterns of the mainstream of society. In this way they are enabled to live, work and participate in the normal environment of the community to the greatest extent possible.
NOVA SCOTIA YOUTH TRAINING CENTRE	This is a provincial residential school, operated by the Department of Social Services for mildly and moderately mentally handicapped children who are educable and trainable.
NURSING HOMES/ HOMES FOR THE AGED	These are facilities which provide Levels I and II care. Nursing Homes are privately owned and operated facilities. Homes for the Aged are operated by municipalities, municipal corporations and private non-profit societies.
PRIVATE NON-PROFIT HOMES	These are facilities operated by an organization incorporated under the Societies Act.
PRIVATE PROFIT HOMES	These are Homes for Special Care which are owned and operated as a private enterprise.
PUBLIC NON-PROFIT HOMES	These facilities are owned and operated by a municipal corporation or a municipality.
REGIONAL REHABILITATION CENTRES	These are facilities which provide an intensive level of rehabilitation for persons discharged from psychiatric services who have the potential to move on to less restrictive alternatives in the community.
RESIDENTIAL CARE FACILITY	Means any building or place, or part of a building or place, where supervisory care or limited personal care without professional nursing supervision is provided to four or more persons who are ambulatory or semi-ambulatory.

RESPITE CARE	This term refers to care provided for a limited period of time, usually short-term, in a Home for Special Care or a Children's Training Centre to persons who normally reside in the community, in order to allow the person who usually provides the care to take a vacation or to attend to commitments.
SENIOR CITIZENS HOUSING UNITS	These are complexes that provide shelter for seniors who do not require any supervision and who are self-sufficient with regard to personal care and maintenance.
VOCATIONAL REHABILITATION WORKSHOPS	These are community-based workshops which develop useful vocational skills related to the social, recreational and functional development of physically or mentally handicapped persons.

HOMES FOR SPECIAL CARE: AN HISTORICAL OVERVIEW[1]

Joseph Howe called them "Mansions of Woe" and indeed those early institutions, which might now fit under the rubric of Homes for Special Care, were neither humane nor praiseworthy. The 1758 Act of the Legislature, which gave authority for the establishment of the first workhouse in Halifax for "homeless and unruly paupers", specified that such persons:

> . . . were to be set to work at useful tasks and punished for idleness or disobedience by being whipped, fettered and shackled, or deprived of their food until they were reduced to better behaviour.

Poor houses, work houses, asylums, hospitals, orphanages; the name varied but they all housed a mixed population of the aged, the sick, the lame, the blind, lunatics and children. A committee of physicians formed to review conditions in one of these institutions in 1832 reported that:

> . . . every room, from cellar to garrett was filled to excess and very unhealthy . . . there were only closed windows . . . no means for ventilation. The building served not only for indigent and aged, but also as a general hospital, a lunatic asylum, an orphan house, a sailor's hospital, and a lying-in hospital.

In the mid 1800's separate facilities for the aged, the insane, children and the poor began to emerge. Many of the new institutions were sponsored by religious groups and some by government, most notably the Nova Scotia Hospital and the Victoria General Hospital. By the latter part of the nineteenth century the municipal level of government had become involved and eleven municipalities were operating mental hospitals. However, the objective of segregation by type of population fell far short of its goal, and conditions were such in many of the institutions that very little pride could be attached to them.

It was not until 1958 and the end of the Elizabethan Poor Law in Nova Scotia that substantial progress began to be made in improving the institutions. With the advent of the Social Assistance Act, municipally operated Homes came under the supervision of the Department of Social Services and costs for residents in

the Homes began to be cost-shared by the provincial government. This, in conjunction with new policy directions for upgrading the poor houses and county homes, resulted in improvements in the standards of care. Responsibility for the mentally ill and the severely mentally retarded rested with the Department of Health and were not affected by these changes.

The next landmark date in the evolution of Homes for Special Care occurred in 1961 with the proclamation of the Nursing Homes Act. This Act marked the beginning of legislated responsibilities for standards of care in privately operated nursing homes.

From 1965 to mid 1984, a period of just nineteen years, major improvements were made in both the establishment of facilities and the delivery of services to the aged and mentally handicapped adults. For the sake of brevity only the major events have been highlighted:

1965 — The Boarding Homes Act was proclaimed requiring each privately operated Home caring for four or more residents to be licensed. Standards for space per resident, fire protection, health care and food preparation were established.

1966 — Responsibility for patients in municipal mental hospitals was reassigned. The Hospital Insurance Commission retained four of the hospitals for the care of psychiatric patients; the remaining five hospitals, together with 870 patients who were considered not to be in need of psychiatric care, were transferred to the Department of Social Services. These five hospitals were renamed Homes for the Disabled.

Other significant events in 1966 were:

- the beginning of the development of four Children's Training Centres in Dartmouth, Digby, Pictou and Sydney

- the establishment of a foster care or Community Residence Program for mentally handicapped adults

- the formulation of an admissions policy and classification criteria for Homes for Special Care;

- the identification of 640 persons from the municipal mental hospitals as suitable for placement in Homes for the Aged.

1972 The Departments of Health and Social Services and the Health Services Insurance Commission agreed upon standards for levels of care and for the classification of persons being admitted to Homes.

1976 The Rehabilitation and Community Services Division of the Department of Social Services was formed and became responsible for all homes for the aged, mentally handicapped adults and mentally handicapped children.

1976 Homes for the Disabled were renamed Adult Residential Centres. A philosophy of deinstitutionalization began to emerge based on the principle of "normalization". This principle states that, where possible, persons needing care should be returned to or maintained in small community settings. This has fundamentally changed perceptions of the needs of the mentally retarded and post-mentally ill.

1976 The Homes for Special Care Act was proclaimed. This Act incorporated the former Nursing Homes Act and the Boarding Homes Act. Regulations pursuant to the Act were passed in 1977.

1977 Sections of the municipal mental hospitals in Cape Breton County and Kings County and the entire Halifax County Hospital were

transferred to the Department of Social Services and redesignated Regional Rehabilitation Centres. These facilities were to provide social rehabilitation and management programs for non-psychiatric residents still housed in municipal mental hospitals.

1976 to 1982 — Group Homes and Developmental Residences for mentally handicapped adults were developed in various centres across the province. The number of homes were increased from four to thirty and the number of beds from forty to 250. One other facility specifically for the physically disabled, was opened in 1982.

1978 — The responsibility for Nursing Homes was transferred from the Department of Health to the Department of Social Services.

1966 to 1984 — Between 1966 and 1984 the number of Homes and the bed capacity, particularly for the elderly, grew in the following ways:

- Thirty new Homes for the Aged were constructed; of these, twelve Homes later had extensions added. Two Homes were replaced. By May 1, 1984 there were thirty-nine Homes for the Aged with 3725 beds.

- Ten new Nursing Homes were constructed or expanded and one was replaced. By May 1, 1984 there were eighteen Nursing Homes with 1445 beds.

1980's — The early years of the 1980's have been marked by an increasing emphasis on the development of community in-home support services and programs for the elderly, the disabled and, to a lesser extent, the mentally handicapped. Increasingly the home and the community are viewed as the primary care setting of choice.

However, care in a Home for Special Care, whether in a small community-based residential facility or a larger institution, is regarded as an essential element in a total care system that is designed to meet individual needs.

PART 1

THE ELDERLY

1.0 THE ELDERLY

1.1 DEMOGRAPHIC TRENDS

The major focus of the Working Groups on Bed Requirements, Classification and Assessments, and Standards of Care was the elderly in Homes for Special Care. This part of the report therefore primarily concerns that population, although many of the comments and recommendations made are also applicable to mentally handicapped adults.

During the past two decades both the number and the proportion of senior citizens in the general population have increased. In Canada as a whole the number has increased by almost one million, from 7.7 percent in 1961 to 9.7 percent in 1981. In that same period in Nova Scotia the number of senior citizens increased by just over 30,000, or from 8.4 percent to 10.9 percent.

Throughout this same period, the majority of senior citizens have continued to live in their own homes. Only 6.1 percent of those Nova Scotians age sixty-five and over reside in Nursing Homes and Homes for the Aged.

The proportion of senior citizens in the Canadian population is expected to increase well into the next century. However, the growth in this segment of the population will be slower in Nova Scotia than in the rest of Canada. While the increase for Canada as a whole is expected to go from 9.7 percent in 1981 to 11.9 percent in 2001, the change in Nova Scotia is estimated to be from 10.9 percent to 11.4 percent. The table on the following page illustrates the projected growth.

POPULATION AGE 65+, CANADA AND NOVA SCOTIA: 1961-2001

	CANADA		NOVA SCOTIA	
Year	Number	Percent of Total Population	Number	Percent of Total Population
1961	1,391,154	7.7	62,055	8.4
1966	1,539,548	7.7	67,279	8.9
1971	1,744,410	8.1	72,470	9.2
1976	2,002,345	8.7	80,730	9.7
1981	2,360,985	9.7	92,560	10.9
1986	2,613,500	10.2	98,400	11.1
1991	2,978,600	11.1	104,700	11.5
1996	3,246,800	11.6	106,900	11.5
2001	3,424,900	11.9	108,000	11.4

Source: 1961 - 1981 Statistics Canada: Census
1986 - 2001 Statistics Canada: Revised Population Projection, No. 3

Beyond the beginning of the next century there is some doubt whether population aging will accelerate, or, if it does, to what extent growth will occur. That uncertainty, combined with our current policy direction of developing in home support services, has implications for our current care system and will affect the way we plan for future needs. It will be necessary to re-examine our care system for the elderly prior to the beginning of the next decade, at a time when population trends and the effect of in-home support programs will be more clearly visible. Accordingly, the Task Group recommends that:

1.1 **A thorough review of the total care system for the elderly be initiated by the Minister of Social Services one to two years prior to 1990.**

1.2 BED REQUIREMENTS

SCOPE OF STUDY

The Working Group on Bed Requirements was requested to examine the following areas:

- the adequacy of the present process and guidelines for establishing bed requirements throughout the province
- the number and location of beds which will be required during the next six years, and the mixes between levels of care
- the appropriate mix of private and publicly supported beds
- the role of the profit and non-profit sectors in responding to identified bed requirements.

Each of these areas was reviewed in relation to Homes for the Aged, Nursing Homes and Residential Care Facilities. The Working Group determined that a total of 138 additional beds would be required to 1991, with 114 allocated between Homes for the Aged and Nursing Homes and twenty-four to Residential Care Facilities.

The Task Group has thoroughly examined Residential Care Facilities and in Part 5 of this report is recommending that a complete review of these facilities be undertaken in order to establish directions and guidelines for the future. In accordance with this recommendation, the Task Group is suggesting that there should be no move to expand the bed capacity in Residential Care Facilities until the review is completed. Consequently, the following discussion of bed requirements relates only to Nursing Homes and Homes for the Aged.

BED REQUIREMENTS

Bed requirements for the adult mentally handicapped and mentally handicapped children are addressed in Parts 2 and 3 of the report. No additional beds have been recommended although there are suggestions for reallocation of beds by type and by region.

PROVINCIAL FORMULA

Although the current formula for determining beds is five beds per 100 persons age sixty-five and over, the actual number of beds in Nova Scotia is higher than this formula allows. On May 1, 1984 the provincial average bed capacity for Nursing Homes and Homes for the Aged was 5.6 beds per 100 persons age sixty-five and over, with a range from 3.5 beds in Cumberland County to 7.4 beds in Halifax County.

In this regard Nova Scotia is in much the same situation as other provinces. Most apply a formula to determine bed requirements but the actual number of beds available is usually higher or lower than would be predicted on this basis. The Canadian average for beds in Homes for the Aged and Nursing Homes is 5.1 per 100 persons age sixty-five and over, ranging from 4.5 in Alberta to 6.8 in Saskatchewan.

The present formula for determining bed needs was evaluated and was considered not to be relevant to today's situation for the following reasons:

(i) it assumes that the need for beds is identical in all regions of the province and can be expressed as a percentage of persons in a particular age grouping. By contrast, a review of the utilization rates by county for October 1983 showed that there were wide variations in the use of beds from county to county.

(ii) there is a discrepancy between the allowable number of beds according to the formula and the actual number of beds

(iii) there are difficulties with the accuracy of the formula in projecting bed needs based on population trends to 1991. According to the current formula, even with an increasing population of persons age sixty-five and over, the total number of beds currently available exceeds the bed requirements until at least 1991.

After comparing four indicators of demand or need - the utilization rate, municipal waiting lists, requests for additional beds and the geographical distribution of existing beds - the Working Group agreed that the best way to determine bed requirements was to use the utilization rate for each county and apply the provincial average utilization rate as a maximum.

The Task Group also perceived a need to set a maximum limit on the formula for a period of time so that bed requirements will not have to be continually recalculated.

The Task Group is therefore making the following recommendations that:

1.2.1 Bed requirements be determined for each county using the utilization rate for the county or the average utilization rate for the province, whichever is lower. That any municipality which requests additional beds and is in a county with insufficient beds as determined by the utilization rate formula be allowed to increase the beds up to the number determined by this formula.

The impact of this recommendation provincially and by county is shown in the Table at the end of this section.

1.2.2 The average utilization rate determined by the Working Group on Bed Requirements be established as a maximum rate until 1991.

PUBLIC/PRIVATE MIX

Almost seventy-five percent of residents in Homes for the Aged and Nursing Homes are publicly supported. There is however, considerable variation from county to county. This variation is attributable to a number of factors: the economy of the region, community attitudes, and the types of facilities available in the area. For example, a county with a larger number of Residential Care Facilities (which tend to be the least costly of the Homes) tends to have less publicly supported residents.

It is very difficult to predict accurately what the future mix of public/private beds should or will be. The proportion of residents who are publicly supported happens to have remained relatively stable during the past five years but this situation could change. Inflation affects the individual's ability to pay and leads to rising care costs in Homes. Such factors could lead to an increase in publicly supported residents.

LEVELS OF CARE

Homes for the Aged and Nursing Homes provide Level I and Level II care. Under the current licensing arrangements these Homes have been permitted to allow the mix of Level I and Level II residents to fluctuate to meet demand, on the condition that they make appropriate changes to meet acceptable standards of care. Capital costs are minimal in converting Level I beds to Level II beds, but there can be significant costs associated with increasing staff.

A recent review by the Classifications and Assessments Section of the Department of Social Services has revealed that 36.5 percent of residents in Homes for the Aged and Nursing Homes are Level I and 63.5 percent are Level II.

BED REQUIREMENTS

The levels of care have varied over the years and will continue to vary reflecting the needs of the current residents and persons who are being admitted to Homes. The Working Group on Bed Requirements could find no correlation between age and the level of care required by the resident, although it was commonly presumed that the older the resident the heavier the care required. Given these factors it is impossible to estimate future requirements for light and heavy care. However, in response to the emerging demand for increased Level II care, the Task Group recommends that:

1.2.3 When a need for additional beds is determined an assessment be made of the feasibility of converting existing light care beds in Homes for the Aged and Nursing Homes to heavy care beds and allocating the additional light care beds to community-based facilities.

ROLE OF PROFIT AND NON-PROFIT SECTORS

Senior citizens groups were particularly concerned about the intrusion of large private entrepreneurs into the Homes for Special Care system. They view the profit motive as being incompatible with the humanitarian principles which form the basis of our care system for the aged, the handicapped, and the disabled. In the care system the individual and his needs should take supremacy over profit.

The operators of private profit Homes, of course, view themselves and the role they play in the care system from quite a different perspective. They say they can and do provide good quality care in an efficient manner.

Nova Scotia's care system has been established with a combination of non-profit and profit making organizations. Over the last quarter century the system of care

facilities and the mix of sponsors have served Nova Scotians well. With very few individual exceptions we have developed and maintained a good standard of care in all facilities.

The Task Group supports senior citizens groups in their concerns that the profit motive never be allowed to supplant or override humanitarian considerations in the provision of care. We do, however, believe that both sectors - private profit and non-profit - should be allowed to co-exist and should have equal opportunities to propose new construction.

BED REQUIREMENTS: 1983-1991, HOMES FOR THE AGED AND NURSING HOMES

	No. of Beds 1983	Utilization Rate	Requirements 1991	Additional Beds
Annapolis	147	4.3	145	-
Antigonish	106	6.9	99*	-
Cape Breton	691	4.6	720	29
Colchester	204	3.6	208	4
Cumberland**	147	2.9	160	13
Digby	147	2.8	96	-
Guysborough	71	4.5	79	8
Halifax	1737	5.9	1476*	-
Hants	255	4.7	188	-
Inverness	120	5.3	135*	15
Kings	239	4.1	255	16
Lunenburg	269	3.6	248	-
Pictou	439	6.2	416	-
Queens	102	5.9	101*	-
Richmond	86	6.4	76*	-
Shelburne	91	5.0	109	18
Victoria	69	5.5	64	-
Yarmouth	182	4.9	193	11
Nova Scotia	5102	4.9	4768	114

* Determined by using utilization rate of 5.0

** Once the 41 beds under construction come into use there will be no need for additional beds in Cumberland County.

1.3 CLASSIFICATIONS AND ASSESSMENTS

INTRODUCTION

In 1965 the Province of Nova Scotia implemented a classifications and assessments system. The system has three objectives: to ensure people being admitted to Homes for Special Care are suitable for placement in Homes; to ensure that they receive the appropriate level of care upon admission; and to see that they continue to receive care consistent with their individual needs as long as they reside in a Home. There are two main components to the system:

- Classification and assessments. The purpose of classification is to determine the eligibility of an applicant requesting admission to a Home for Special Care. If the person is determined to be eligible, an assessment is made of the type of care and/or programming the individual requires.

- Re-assessment. Re-assessments of the residents of Homes are undertaken on a quarterly, semi-annual or annual basis to determine the individual's level of functioning and care needs, and to ensure that these specific needs are met.

The classification system relates only to those persons applying for admission to municipally operated Homes and for those who require public financial support in all other Homes. It is used to establish eligibility for cost-sharing between the individual's Municipality of Settlement and the Province.

The Department of Social Services has the legislated responsibility both for assessing and classifying applicants for admission to Homes for Special Care, and for any appeals. Under Part II of the Municipal Social Assistance Act, the Municipality of Settlement is responsible for submitting an application for classification and for implementing the decision of the Classifications Committee.

The Municipality must apply to a specific Home for an applicant to be admitted. The decision whether or not to admit the individual rests with the Home.

In the following pages, the issues, concerns and structure of our present classifications and assessments system will be examined and discussed. Most of the text is drawn from the Report of the Working Group on Classifications and Assessments; however the Task Group has made changes where it felt it to be necessary, particularly for clarity and to avoid duplication.

APPLICATION PROCESS

The municipality is responsible for providing money, goods and services for persons in need. Thus, if an individual requests admission to a Home for Special Care and has insufficient funds to pay the cost of the care, he or she may make an application for financial support to their municipality of residence. The municipality must determine whether or not the person is in need and is consequently eligible for assistance, and whether or not the care required can best be provided in the person's own home, in the community or in a Home for Special Care. The decision of the municipality is subject to appeal.

At the beginning of this report the Task Group stated its support for the principle of maintaining people requiring care in their own homes or in community settings wherever and whenever possible, and also for as long as possible. For publicly supported residents, the municipalities are in the front line in providing services. They therefore have the responsibility to ensure that choices are available to the applicant. Accordingly, the Task Group recommends that:

1.3.1 An applicant's Municipality of Settlement shall refer an application for classification only if it cannot arrange for accommodation and/or services in a suitable setting outside a Home for Special Care.

If placement in a Home is deemed necessary, the Municipality of Settlement must arrange to have an application submitted for classification purposes. Since over fifty percent of all referrals for classification originate from hospitals, the role of the hospital is crucial in the preparation process. It is essential that hospitals provide adequate discharge planning for applicants in order to give the Municipality of Settlement sufficient time to prepare the necessary documentation for classification and placement. As well the hospital should also provide a comprehensive pre-discharge plan in order to facilitate the classification and assessment process and ensure a placement is made which is consistent with the individual's needs. With this in mind, the Task Group recommends that:

1.3.2 Each person being referred by hospital staff to the Municipality of Settlement for classification have a current comprehensive, multi-disciplinary, pre-discharge plan developed by the pertinent service delivery units of the hospital, and that the plan include reasons for the referral for placement.

1.3.3 For young mentally handicapped applicants who are being referred for placement in specialized adult facilities for the mentally handicapped the referring source should submit a current individualized, comprehensive, multi-disciplinary plan (based on a rehabilitation/developmental model) to the Classifications Committee.

The Task Group believes that the role of the Municipalities of Settlement would be enhanced if some staff were organized on a regional or county basis, who were specialized in both the preparation of applications and the placement of applicants in Homes for Special Care. These specialized staff members would be required to keep pace with, and develop expertise in the fields of mental retardation, mental illness, physical care and gerontology, through appropriate staff training; become

familiar with care/program requirements for individual applicants; develop a working relationship with hospitals, medical doctors, Homes for Special Care and other service entities and professionals; and become adept in the development of the community-based resources vitally needed to keep applicants in their own homes. This enhanced role would allow the workers to visit their clients on a more regular basis than at present and would result in increased staff familiarity with the needs and interests of their clients. This regional group would be expected to play an important role in any decentralization of the classifications and assessments process. The Task Group wishes to encourage this type of development and therefore recommends that:

1.3.4 Staff having responsibility for preparing applicants for admission to Homes for Special Care and for the placement of such applicants should be organized on a regional or county basis.

CLASSIFICATION PROCESS

The eligibility criteria for classifications are derived from the Agreement on Levels of Care between the Departments of Health and Social Services. There are five Levels of Care: Level I is supervisory and limited personal care; Level II is intensive personal care with nursing supervision (commonly referred to as nursing care) provided in Homes for Special Care; Levels III to V refer to the care provided in facilities which are the responsibility of the Department of Health.

At present, persons requesting placement in Homes for the Aged, Nursing Homes, and Residential Care Facilities are assessed and classified according to the level of care required — supervisory, personal or nursing care. Each type of Home is designated for a particular level or levels of care.

CLASSIFICATIONS AND ASSESSMENTS

Persons requesting admission to the Specialized Adult Facilities for the Mentally Handicapped are assessed and classified for a specific category of Homes (such as Regional Rehabilitation Centres, Adult Residential Centres, Group Homes or Developmental Residences) rather than a specific level of care. These Homes are licensed to provide the necessary, individualized development and rehabilitation programming required by each resident. Classifications for these facilities, unlike those for Nursing Homes, Homes for the Aged and Residential Care Facilities, are done by local classifications staff of the Department of Social Services. The system of classifications for services to mentally handicapped adults was decentralized in 1975.

Because development of community-based residential facilities has not kept pace with demand a dual classifications system has been introduced. This means that a mentally handicapped person approved for placement in a Group Home may also be approved for placement in an Adult Residential Centre. A dual classification is made in order to facilitate placement and to assist the Municipality of Settlement to avoid overstay charges in hospitals.

The policy of making a dual classification causes serious concern to advocate groups who argue that consideration must always be given to assuring that the applicant is placed in the most appropriate, least intensive type of care and programming setting; preferably not in an institution. The Task Group recognizes both sides of the problem and by way of compromise recommends that:

1.3.5 When mentally handicapped persons are classified, dual classifications shall continue to be made wherever necessary. Nevertheless, should the appropriate level of care and programming not be available within a municipality to meet an individual's needs, a time limit of twelve months will be applied to the approval that allows the resident to remain in a less suitable program setting. Within this period of time the funding

municipality should arrange for the more appropriate service to be made available to the client.

If the Municipality of Settlement does not provide the approved service at the end of twelve months, the Department of Social Services shall discontinue cost-sharing of the payment of the maintenance costs of the resident. For residents in Regional Rehabiliation Centres, the Department shall charge 100 percent of the maintenance costs to the Municipalities of Settlement.

Classification decisions are relatively well accepted except for those "borderline" cases which fall between the jurisdictions of the Department of Social Services and the Department of Health, that is, between Level II care and Level III care. The availability of Level III care beds is limited, placing undue pressure on the classifications system to accept Level III care patients in Homes for Special Care. With these problems in mind, the Task Group recommends that:

1.3.6 A committee comprised of representatives from the Departments of Health and Social Services be established to refine the definitions and to resolve the discrepancy relating to the levels of care to be provided in Homes for Special Care and health facilities.

The committee's mandate shall also include the development of detailed criteria for:

- **Extended Care**
- **Nursing Care as provided in Homes for the Aged and Licensed Nursing Homes**

- **Limited Personal Care as provided in Residential Care Facilities**
- **Supervisory Care**
- **The placement of mentally handicapped persons in Homes for the Aged and Licensed Nursing Homes. These mentally handicapped persons include the psycho-geriatric residents in Regional Rehabilitation Centres and those residents in Adult Residential Centres receiving intensive personal care.**

Owing to the large volume of classifications (3,433 in the fiscal year 1983-84) and the discharge practices of some hospitals which allow only two to five days lead time for discharges, the majority of classifications are done by classifications Officers alone. However, the full Classifications Committee is convened at in-patient psychiatric facilities and at meetings of the Local Classifications Committees. The inter-disciplinary Classifications Committee is comprised of the Department of Social Services representative (as Chairperson), the regional Medical Director for the Department of Health, and a representative of the Municipality of Settlement.

If the person is not placed within the hospital's discharge period, its per diem rate is paid by the applicant's Municipality of Settlement for each additional day. The per diem rate for any hospital would be greater than that of any Home; consequently, there is great pressure to have classifications from general hospitals completed very quickly.

In this context the Task Group recommends that:

1.3.7 The local Classifications Officers continue to perform their delegated responsibilities until they become incorporated in the

proposed decentralized system, and that they continue to liaise with the Regional Health Directors as the representatives from the Department of Health.

Further, that the Classifications Committee, when convened at a Psychiatric Facility alone, be a multi-disciplinary team consisting of a departmental representative as chairperson, the Clinical Director of the hospital (or his/her representative) instead of the Regional Medical Director, and a representative from the Municipality of Settlement.

PLACEMENT/ADMISSION PROCESS

The Municipality of Settlement not only submits the application, but must also make the necessary placement arrangements after classification has been completed. The Municipality of Settlement must apply to a specific Home (in the category approved) in order to have the applicant admitted. The Home determines whether or not to accept the person. At times, a Home has refused to admit suitably classified applicants. The Task Group recommends that:

1.3.8 **Each Home for Special Care be required to serve a specific catchment area. Should the Home, having an appropriate vacancy, refuse to admit the applicant, its decision shall be subject to appeal.**

A related placement issue is the refusal of applicants to leave the hospital after being classified, and after the Municipality has made attempts to have them placed. Similarily, some applicants have refused placement in particular Homes,

but have asked to be admitted to another Home, that offers the same level of care and programming but may be more expensive for example, a newly built Home.

In both instances, the appropriate Municipality of Settlement has discharged its obligation by trying to place the individual. It cannot coerce the individual into being admitted since all admissions are done on a voluntary basis. This situation poses a very serious problem for the Municipality of Settlement, which, in all likelihood, will be billed by the hospital for overstay charges. This matter must be resolved by the Departments of Health and Social Services in order to forestall any future problems. The Task Group recommends that:

1.3.9 The problem of patients refusing to leave hospital after the Municipality of Settlement has attempted to provide the required service should be addressed by the Senior Inter-departmental Committee of Health and Social Services. It should seek to establish clear policy guidelines to cover this issue making particular reference to Sections 9 and 10 of the Hospitals Act.

REASSESSMENTS

Reassessments are undertaken to ensure that the resident continues to receive the level of care and programming he or she requires. A local Community Health Nurse conducts the reassessments twice a year on all residents in Homes for the Aged and Licensed Nursing Homes whose capacity exceeds 35 residents. Special reassessments may be requested by these Homes in certain circumstances. Departmental licensing staff also reassess all residents in Homes for Special Care, including Residential Care Facilities, twice a year when the Home's license is reviewed. Moreover, annual reassessments are conducted in Regional Rehabilitation Centres, Adult Residential Centres, Group Homes, and Developmental Residences by an interdisciplinary team selected from persons

outside the facility, in conjunction with staff knowledgeable of the particular resident being reassessed.

The recommended changes for the current reassessment process are related to ongoing in-facility reassessments of all residents (including private-paying residents in privately-operated Homes who were previously excluded), and the time limit within which inappropriately placed residents must be admitted to other options. The Task Group recommends that:

1.3.10 All residents in Homes for Special Care, including private-paying residents in privately-operated homes, be reassessed in accordance with departmental policy.

Internal reassessments on all residents in all Homes be conducted at least quarterly, in a format that can be readily reviewed by staff of the Department of Social Services.

The local community health nurses of the Department of Health continue to conduct reassessments in Homes for the Aged and Licensed Nursing Homes.

If a resident of a Licensed Nursing Home, Home for the Aged or Residential Care Facility is reassessed and found to need a level of care different from that which the facility is licensed to provide, and if the resident is not transferred within 30 days of the decision, the Department shall not cost-share maintenance costs of the resident in that facility. This recommendation does not apply to residents requiring hospital care whose hospitalization shall be immediate.

The reassessment team for Regional Rehabilitation Centres, Adult Residential Centres, Group Homes and Developmental Residences should consist of the Supervisor of Classifications and Assessments, and other representatives appointed by the Supervisor.

If a resident of a Regional Rehabilitation Centre, Adult Residential Centre, Group Home, or Developmental Residence is reassessed as requiring a type of programming different from that which the facility is licensed to provide, and if the resident is not transferred within a period of three months of the decision, the Department shall withdraw cost-sharing of the resident in that facility. For Regional Rehabilitation Centres, the Municipality of Settlement must then pay 100 percent.

HOSPITALIZATION OF RESIDENTS

From time to time, Homes for Special Care have experienced difficulty in having persons, who, in their opinion, require hospital care, admitted to hospital. Since admission to hospital is determined by a physician and also by the hospital itself, there have been instances where physicians have refused to refer residents, or where residents have been referred but the hospital has refused to admit them. Situations such as these create serious problems for both the Homes and the Municipalities of Settlement. These residents should not remain in a Home for Special Care, but neither the Home nor the municipality have any power to insist that the persons be admitted to hospital. A recent survey has indicated that there are approximately fifty-seven residents in Homes for Special Care who, for one reason or another, require Level III or Extended Care in a hospital setting.

Residents with chronic medical conditions are reluctantly admitted to hospital. When the acute phase is over, they are quickly returned to the Homes — even though, according to the classifications criteria, their needs exceed the level of care provided by the Homes. It is not uncommon for such persons to be returned to the Homes on weekends when regular staff are away. Such persons are not normally approved for readmission and this type of decision creates an adversarial situation between the hospital and the Classifications and Assessments Section. Subsequently many hospitals are unwilling to admit such persons because they fear they will remain in the hospital's charge. This issue is related to the broader one discussed earlier, in which there were misinterpretations and misgivings between the respective responsibilities of hospitals and of Homes for Special Care (that is, between Level II and Level III care). In order to improve this difficult situation, the Task Group recommends that:

1.3.11 **Local liaison committees comprised of representatives from the Departments of Health and Social Services, the Municipalities of Settlement, and the Homes for Special Care be established to meet periodically with the local hospitals in order to resolve any issues and concerns.**

Every resident of a Home for Special Care who requires hospital care should be admitted immediately to hospital.

The issue of having residents of Homes for Special Care hospitalized should be addressed by the Senior Interdepartmental Committee of Health and Social Services in order to establish clear policy guidelines.

Any disputes regarding the hospitalization of residents should be referred to a standing committee comprised of representatives of the Senior Interdepartmental Committee on

Health and Social Services in order to resolve individual cases in light of the policy guidelines.

APPEALS

It is a recognized principle that decisions made by Municipalities of Settlement and Classifications Committees with respect to applications are subject to appeal. In addition, the decisions of reassessment teams should also be subject to appeal. The Task Group recommends that:

1.3.12 Decisions of the reassessment team should be subject to appeal.

The manual on appeals should more precisely incorporate policies and procedures relating to all appeals, and should pay particular attention to the following areas:

(a) the types of appeals which can be made, who is authorized to make them, on what grounds, and in what manner

(b) the composition of the Appeal Board and its Terms of Reference

(c) the Right to Representation

(d) the requirement that the Appeal Board must state the reasons for its decisions.

DECENTRALIZATION

Decentralization of classifications and assessments has been investigated as a possible way to deal with many of the problems that have been discussed. It has two parts: the re-admission process and the classification process which are discussed briefly as follows:

(a) Re-admission Process

To facilitate the re-admission of hospitalized residents to Homes for Special Care, the Department of Social Services has established a policy of allowing beds in the respective Homes to be held for a hospitalized resident for a period of thirty days, depending on the vacancies in the Home and the prognosis of the resident. The Department has also provided an abbreviated medical form to be completed for such persons in order to expedite their re-admission.

Despite the Department's attempts to expedite the re-admissions process, there have at times been delays in having hospitalized residents re-admitted to Homes. These delays have become, understandably, a source of irritation to some hospitals. In these situations it is probably more expeditious and appropriate for the approval for re-admissions to be carried out not by the Classifications and Assessments Section, but rather at the local level by the Municipality of Settlement in conjunction with the Home for Special Care. The only exception would be for those residents who are hospitalized in the Halifax/Dartmouth area. The Task Force recommends that:

1.3.13 The approval process for the re-admission of a hospitalized resident of a Home for Special Care, whose bed is being held in accordance with departmental policy, should be decentralized to the Municipality of Settlement in conjunction with the Home for Special Care. The exception to this would be when the person is hospitalized in the Halifax/Dartmouth area but has settlement outside this catchment area.

(b) Classification Process

The main impetus for decentralization of classifications originated with the staff of general hospitals (mainly in the Cape Breton and Western regions) who complain about discharge delays. They believe that decentralization would hasten the

classifications and placement process and avoid delays in having patients discharged from hospital to Homes for Special Care. However, meetings with other hospital officials to discuss alleged classifications delays have revealed that the issue is primarily one of placement and not classifications. Placement is the responsibility of the Municipality of Settlement and should be distinguished from classifications which fall under the jurisdiction of the Department of Social Services. In other words, the problem, whether a lack of vacancies or the refusal of the person to be placed, is a local one.

In the Task Group's opinion, increased communication between local hospitals and municipalities, the issuing of discharge notices in accordance with the Hospitals Act, adequate pre-discharge planning by hospitals, and the development of the specialized group of municipal workers would minimize delays in placement. To illustrate this, the hospitals in the Halifax/Dartmouth region, where approximately fifty-five percent of all referrals from hospitals originate, are very rarely encumbered with placement delays.

The decentralization of the classifications process is certainly possible. However, it should only occur as part of a comprehensive plan incorporating classifications, reassessments, and licensing.

In light of the foregoing, the Task Group recommends that:

1.3.14 The Department of Social Services establish a pilot project in the Cape Breton Region for the complete decentralization of classifications, reassessments, and licensing.

1.4 STANDARDS OF CARE

Standards of Care is perhaps the most sensitive and elusive area to examine, and is usually equated with the quality of life of residents in Homes for Special Care. There is no one all-encompassing measurement, guaranteed method or basis for determining the quality of life. In order to avoid this problem of definition, the Task Group and the Working Group have examined instead those elements -physical setting, staffing, program and administration - which constitute standards of care and which are reflected in the end product; the quality of life provided.

During visits to facilities in other provinces, it was clear that the standard or quality of care currently provided to residents in most Homes for Special Care in Nova Scotia is comparable with, and often better than that being provided elsewhere. That does not mean that we cannot improve our current system of care, but it does mean that we have a solid foundation on which to make those improvements. This section of the report is devoted to an examination of some possible avenues for improvement.

CONSTRUCTION AND DESIGN

Administrators and residents of Homes for the Aged and Nursing Homes were very concerned about the design of these Homes and had many suggestions for future construction and improvements to existing facilities. A survey was conducted to determine what they considered to be the positive or negative feature of their Homes. Their comments paralleled those made in presentations to the Task Group, particularly by Canadian Pensioners Concerned. Of utmost importance to all three groups were single storey construction, a good location, accessibility to and from the outside, interior design and privacy.

In Nova Scotia there are few legislated requirements covering the design and construction of Homes, except in terms of space, and the necessity for obtaining ministerial approval for new buildings or the expansion of existing buildings. In order to obtain approval, however, there is a process which must be followed.

Plans must be submitted to the Department of Social Services, the Office of the Provincial Fire Marshall and the Department of Housing. Legislated space requirements and the Fire Marshall's requirements must be met. For construction funded by Canada Mortgage and Housing Corporation, the cost of building must not exceed their maximum unit price.

Except for the Office of the Fire Marshall, staff of the other Departments involved in the approval process can only offer advice or express opinions to the owner and his architect on the appropriateness and efficiency of the building design. In the final analysis the actual design and construction are the responsibility of the owner and architect, with the final decisions left to their discretion. They must determine the most efficient and cost effective building design to construct.

In years past program considerations did not often enter into the discussions on design and were therefore not reflected in the finished product — the Home for Special Care. In fact, on many occasions the building was completed prior to the development of the program. This frequently caused problems later in terms of the appropriate utilization of the facility.

Like Nova Scotia most of the other provinces have legislated space requirements for Homes, and a few have manuals or guidelines for construction and design. Only one province, Alberta, has a consultant architect on staff to give advice and to assist persons with the design of new facilities.

Guidelines for construction and design of Homes for Special Care have been developed at a national level and can be adapted to provincial needs. The Task Group believes Nova Scotia should examine these guidelines, and use them as a basis for the development of a manual on construction and design for use in this province. The Task Group, therefore, recommends that:

1.4.1 In co-operation with representatives of the Associated Homes for Special Care and Senior Citizens Groups, the Department of Social Services establish guidelines for the construction and design of Homes for the Aged and Nursing Homes.

The Working Group on Standards of Care made a number of detailed recommendations on construction and design. Those related to such things as storage space, dining and activity space, the level of windows, colour schemes and bathrooms have not been included in this report. They should, however, be incorporated in a manual or booklet on guidelines for construction and design, along with the recommendations which follow.

1.4.2 Where practicable, depending upon size and location, Homes for the Aged and Nursing Homes should be of one storey construction.

One storey buildings are initially more costly to construct than multi-storey buildings but they offer distinct advantages:

- they afford greater accessibility to the outside for residents
- there are savings in staff time taken up in assisting residents to move from one floor to another as they participate in daily activities, and in the supervision of residents
- they facilitate evacuation during emergencies.

1.4.3 The location of all Nursing Homes and Homes for the Aged in the community should give residents easy access to community services.

Residents who have any degree of mobility like to be able to take part in community activities and services. Homes should be located so as to assist residents in maintaining as much independence as possible.

1.4.4 All Homes for the Aged and Nursing Homes should be restricted to a size range of 50 to 125 beds.

In Nova Scotia, the size of Homes ranges from eleven beds to 585 beds. The average size of the Home for the Aged or Nursing Home is eighty-eight beds. The desireable size for a Home in terms of maximum efficiency of cost, staffing, resident care and quality of life was discussed during presentations, as well as with administrators of Homes and government officials in other provinces. There was general agreement that the minimum and maximum sizes recommended best meet administrative and care needs.

1.4.5 Resident rooms in Homes for the Aged and Nursing Homes should provide 120 square feet of free space for each resident.

Current legislation requires a minimum of 120 square feet of space for a single room with sixty square feet for each additional person. These minimum requirements have been adopted for the construction of the majority of Homes. In most other provinces the space requirements are approximately the same as in Nova Scotia. This recommendation reflects the fact that operators and residents of Homes believe more space is required to allow for the free movement of wheelchairs and walkers, and furniture such as bed side tables, bureaus and chairs.

1.4.6 The occupancy of bedrooms in Homes for the Aged and Nursing Homes should be limited to a maximum of two residents. Each new Home should be required to designate at least half of its rooms to single occupancy. Existing Homes should be required to provide privacy curtains in multiple occupancy rooms.

Privacy was the single most important element desired by the residents surveyed. Multiple occupancy rooms give rise to problems such as incompatibility and dissension among residents sharing the same close quarters, and difficulty in individualizing programming. Many provinces are moving toward more single occupancy rooms and some, namely Alberta, Saskatchewan, Manitoba and British Columbia, require the majority of rooms in Nursing Homes and Homes for the Aged to be single occupancy.

1.4.7 Existing older buildings should not be converted to Homes for the Aged or Nursing Homes.

The basic difficulty in converting older homes is that they were designed for other purposes and are not easily adapted to the care of the elderly. Generally, rooms are too small, all areas are not wheelchair accessible, doorways and corridors are narrow, dining and recreation space is not sufficient, and they afford very limited privacy for residents.

STAFFING

The only legislated requirement[1] for staff in Homes for Special Care in Nova Scotia relates to coverage by a registered nurse in Nursing Homes and in Homes for the Aged. If there are less than thirty residents in these Homes a registered nurse must be on duty for no less than eight hours every day. Where there are over thirty residents requiring Level II care, a registered nurse must be on duty at all times. Aside from the legislation, there are staffing guidelines which were first developed by the Department of Social Services in 1970 and revised in 1980. These guidelines include a formula for determining the numbers of direct care staff and also establish a base for staff in other areas such as dietary services, laundry and maintenance.

Briefs submitted to the Task Group from several professional organizations made positive suggestions for staffing levels from the perspective of their particular fields of expertise. They recommended that staffing guidelines be revised to reflect both their recommendations and current care needs. In addition, Boards of Management and professional staff of Homes saw a need for additional skilled staff because of the substantial increase in the number of residents in Nursing Homes and Homes for the Aged requiring heavier care.

Unlike Nova Scotia, most provinces only have guidelines for nursing and direct care staff. These do not include minimum and optimum guidelines for direct care. In most cases their legislated staffing requirements relate to the number of hours of care which must be provided by direct care staff under the supervision of a registered nurse.

Most other provinces do indicate in their guidelines what percentage of staff must be registered nurses, certified nursing assistants or other direct care staff. This results in slightly higher numbers of professional care staff and lower numbers of non-professional direct care staff than are found in Nova Scotia. Weighting in this direction is balanced by the fact that Nova Scotia's guidelines permit a more generous overall staff to resident ratio. In fact, Nova Scotia compares very favorably to other provinces in terms of staffing.

It is not possible to address at length all the concerns presented to the Task Group and Working Group regarding staffing. In this section of the report recommendations relating to the major concerns are made followed by brief supportive comments, where applicable.

The recommendations are reflective of the Task Group's belief that every Nursing Home and Home for the Aged should be required by legislation to have Registered Nurses, Certified Nursing Assistants and Personal Care Workers in sufficient numbers to ensure a high quality of care for residents. In addition, persons skilled

in rehabilitation and reactivation techniques should be included as part of the direct care staff. The role and function of each professional and/or direct care grouping should also be defined for each facility.

1.4.8 In consultation with Homes, the Department of Social Services should establish staffing guidelines for all Homes to which current guidelines do not apply.

As was previously mentioned the staffing guidelines which now exist apply to Nursing Homes and Homes for the Aged. Future problems may be avoided in other Homes if clear, comprehensive guidelines for staffing are developed in accordance with the recommendations of the Task Group and Working Groups.

1.4.9 Requirements for personnel in appropriate numbers and with appropriate qualifications should be established in legislation to ensure the provision of supervision, care and programming in accordance with the type of facility, care or program requirements of the residents.

The staff to resident ratio of direct care staff was a matter of vital concern to residents, professional groups, consumer groups and the Homes. Confusion existed about current staffing guidelines and their adequacy to ensure that sufficient numbers of direct care staff are available to meet residents' needs. These concerns were expressed specifically in relation to Nursing Homes and Homes for the Aged. Here, legislation establishing the numbers of direct care staff was seen as reassurance that the standards and quality of care will be maintained in these Homes.

1.4.10 In conjunction with recommendation 1.4.9, the minimum qualifications for Administrators and Directors of Nursing in

Nursing Homes and Homes for the Aged be established and legislated.

In Nova Scotia, there is no legislation which sets out the requirements for Administrators or Directors of Nursing, although there are guidelines for administrator positions. Only one province, Ontario, has such legislation in place.

In many presentations it was stated that such legislation is needed to ensure that the persons filling the two key positions in Nursing Homes and Homes for the Aged are skilled professionals who are knowledgeable and able managers. These two positions were regarded as the most important in ensuring both the efficient operation of each Home, and a high quality of care and programming to each resident.

The Task Group suggests that if this recommendation is adopted, representatives of the Administrators and Directors of Nursing be involved in the establishment of the minimum qualifications for their respective categories.

1.4.11 In Homes of less than fifty beds the positions of Administrator and Director of Nursing should be combined.

It seems a more effective utilization of the public dollar to have these two positions combined in the smaller Homes. In fact, in Homes where this combination now exists very good administrative and care standards have been maintained. With a number of registered nurses either opting to return to university for Bachelor of Nursing Degrees or starting their careers through that route, the people should be available with the combination of skills required for these combined positions.

1.4.12 Homes of 100 beds or more shall be required to have a full-time physiotherapist and occupational therapist. Homes of less than 100 beds should employ these professionals on a part-time basis.

During the course of the Task Group's work, a survey to determine the levels of care required by residents of Nursing Homes and Homes for the Aged was undertaken by the Department's Classification and Assessments staff. Their findings clearly show that two-thirds of the residents require heavy care and one-third require light care. This pattern is the reverse of the situation a few years ago.

Maintaining and increasing the mobility of residents must be a priority. The Working Group also noted that every resident has the right to function at his optimum level, and every Home has the responsibility to ensure this right by providing the necessary services and programs. Aside from these considerations, if services and programs to sustain or increase the physical functioning of residents are not provided, serious consequences for the residents' quality of life and the staffing requirements of the Home may result.

The staff-to-resident ratio of physiotherapists and occupational therapists included in the recommendation is based on discussions with the respective professional organizations. Although appropriately trained professionals are not readily available in equal measure in all parts of the province, both organizations offered to assist Homes in finding members of their organizations who may consider working full or part-time. Another option is to consider joint employment with local Department of Health facilities.

With regard to additional cost, the Task Group suggests that an examination of the

existing staff complements of Homes may well show that these professionals can be hired within current budgets and established staff complements.

1.4.13 Training opportunities should be provided for all staff in Nursing Homes, Homes for the Aged, and Adult Residential Centres both on an in-service basis and by involvement in external training programs relevant to their individual positions. In this case the objective would be to have seventy-five percent of the staff of Homes trained by 1987.

Existing in-service training programs are geared toward direct care staff. However, all staff have contact with residents and they not only need to have knowledge of changes and innovations in their specific work areas, but also an increased understanding of the people they serve. There are many courses available for these staff and they should have the opportunity to upgrade their skills and knowledge.

PROGRAMS

This section does not contain comments or recommendations on all programs in Homes, since it was impossible to conduct a detailed review of every program. The Task Group has instead highlighted those areas brought to its attention most frequently which require change or updating, as well as new programs which may enhance the lives of the residents.

The Regulations accompanying the Homes for Special Care Act[3] require Homes for Special Care to provide social, vocational, educational, religious and recreational programs and activities for residents. The type and extent of programs provided vary from one facility to another, with most large facilities having a wider variety of programs than smaller ones.

The philosophy of the Homes is to encourage residents to participate in community life, where possible, by attending church, going shopping and so on. In addition, community participation in the Homes is also encouraged by enabling volunteers to provide activities or meet the residents' spiritual needs.

A disturbing aspect of programming which was discovered through a survey conducted by the Working Group was that most residents felt they had very limited influence or input into the types of programs offered in their Homes. The Task Group trusts this feeling will be avoided in the future by the introduction of Resident Councils (made mandatory in Homes for Special Care on March 6, 1984). These Councils should have a significant impact on all aspects of life in Homes.

Homes for Special Care in other provinces seem to offer similar levels of programming to Nova Scotia. The variety and scope varies from one home to another, but, as in Nova Scotia, only basic program requirements are legislated.

Since there are no provincial guidelines which can be used to expand upon the legislated requirements, or to establish a base line for the development of other programs in Homes for Special Care, the Task Group recommends that:

1.4.14 Provincial guidelines be established for all types of programs in Homes for Special Care.

Within the new guidelines, provision should be made for programs related to special groups such as those residents requiring psychogeriatric care. In addition, the Task Group assumes that in establishing guidelines a further review of current programs and projected program needs will be undertaken.

The Task Group and Working Group on Standards of Care were asked to examine four specific program areas: the role of volunteers in Homes, intergenerational programming, pastoral care, and the way in which Homes can be supportive of

seniors living in the community. The latter area is addressed in Part 8 of the report. Our comments on the other three areas are as follows:

- Volunteerism is an important element in modern society. Volunteers have already given many hours of service to Homes for Special Care. Most volunteers are recruited in an informal manner from the community in which the Home is located. The degree of involvement of volunteers in Homes depends upon the emphasis placed on volunteers by the individual Home, and on the intensity of efforts to establish a volunteer program. The Task Group believes volunteer recruitment, selection and training could be enhanced if each Home designated a staff member to be responsible for volunteers, at least on a part-time basis. Efforts to this end should be encouraged by the Department of Social Services.

- Intergenerational programs usually mean that Homes either house or have affiliations with day care centres, schools and universities, and youth groups. Intergenerational programming has developed naturally over a number of years and the Task Group feels that this should be encouraged to continue.

- Pastoral care was discussed with residents and was mentioned or examined thoroughly in several briefs. Generally, the Task Group is of the opinion that the spiritual needs of residents in Homes are being met by current arrangements between the local clergy and the individual Homes. We are very aware of the importance of spiritual care for residents in Homes, and of the difficulties which exist in some of the larger facilities and larger communities where a multiplicity of religions need to be represented. In these instances, there may well be a need for a pastoral co-ordinator. The Task Group suggests that each situation be reviewed individually and

arrangements be made to include such a position in the budget where it is deemed necessary. The per diem rate should then be adjusted appropriately to reflect the extra cost.

OTHER CONCERNS

(a) Administration

Administrative policies and practices should be clearly established by Boards of Management for the direction of senior administrative staff and other personnel. Written documentation of this type will contribute to the smooth and efficient functioning of the Home and staff. In many Homes such things as Resident Care Plans, Manuals of Personnel Policy, Personnel Files and Procedures, Accounting Practices, Budgeting Reporting and Procedures would be very useful but are not available. The Task Group recommends that:

1.4.15 In co-operation with the Associated Homes for Special Care, the Department of Social Services produce for use by Homes a manual of organizational and management procedures and guidelines consistent with the needs and programs of each type of Home.

(b) Pharmaceutical Services

This subject has been a particular concern of professional associations, Homes and the Department of Social Services. In April 1984 a review of current practices involving the pouring and administering of drugs was undertaken. In the majority of Homes medications were poured by registered nurses, but were frequently given by another staff person. A number of the larger Homes use the unit dosage system, but this is not always the case. In the interest of safety and efficiency, the Task Group recommends that:

1.4.16 Nursing Homes, Homes for the Aged, Adult Residential Centres and Regional Rehabilitation Centres be required by legislation to have a consulting pharmacist. Subject to review and approval by the Department of Social Services, each Home should establish procedures for the proper control and safe administration of drugs.

1.4.17 All Homes should be encouraged to use the Unit Dosage System.

(c) Medical Services

The Homes for Special Care Act and Regulations (Section 25, subsections 1, 2, and 3) require each Home for Special Care to have a qualified medical practitioner as a medical health advisor. The function of this position is to review and advise the administrator, owner, or Board of Management of the Home on all matters relating to the physical and mental health of the residents. The current policy regarding who is responsible for funding these medical consultations is unclear. The Task Group is of the opinion that the position of medical advisor is necessary to provide leadership in developing medical care policies and to ensure the general health and safety of residents. It is therefore recommended that:

1.4.18 The Department of Social Services establish an agreement with Medical Services Insurance for the inclusion of the medical advisor consultations within the insurance provisions.

(d) Oxygen Therapy

The question of the administration of oxygen therapy in Homes for Special Care was raised only once in all the representations made to the Task Group. Although oxygen therapy was not considered to be a major or pressing matter, the Task Group along with the Working Group on Standards of Care did examine the issue.

The following comments are made to clarify some of the issues and concerns which were expressed.

There are two distinct oxygen therapy delivery systems - conventional and oxygen concentrator. Oxygen concentrators are the safer of the two, and there was general agreement that when oxygen concentrators are used safety is not an issue.

The primary consideration in terms of the use of oxygen therapy in Homes for Special Care relates to the definition of the levels of care provided in these facilities. The levels of care provided in Nursing Homes and Homes for the Aged in Nova Scotia are based upon nationally accepted definitions.[2] Intensive personal care is defined as, assistance with bathing, grooming, eating, dressing, administration of drugs, care of incontinent persons, catheter care, injections other than intravenous and simple exercises. It does not include such procedures as intravenous and oxygen therapy on a continuous basis. Oxygen therapy can be found within the definition of Extended Hospital Care - Level III, which is the responsibility of the Department of Health.

Most provinces do not permit the use of oxygen in Homes for Special Care. The primary reason is that the necessity for oxygen therapy indicates a level of care beyond that which the Homes are staffed or licensed to provide. It should also be noted that the introduction of oxygen therapy in Homes means increases in costs,[3] both in terms of the equipment and the additional number of professional staff required to monitor the treatment.

The Classifications and Assessments Working Group has recommended that the Department of Health and Social Services re-examine the levels of care and redefine them. Until that review is complete, the Task Group suggests that no change be made in the current levels of care. This means that, for the present, oxygen therapy will continue to be disallowed in Homes for Special Care.

(e) Licensing and Inspection

In the Province of Nova Scotia reference is made specifically to the licensing of Homes for Special Care in both the Act and Regulations. For the purposes of those sections of the Act and Regulations which address licensing, the Minister of Social Services may appoint staff as inspectors of facilities.

The Department of Social Services employs one Chief Inspector and three inspectors whose primary role is to ensure that the Homes comply with the Act and Regulations in their entirety. The Act and Regulations define the areas in which inspections are to be made. In addition, the Office of the Fire Marshall and the Department of Health carry out inspections for their respective areas.

The Department of Social Services has not formalized reporting procedures to Homes as a follow-up to regular inspections. Where there is a problem it is noted in the report from the inspector to the Provincial Director of Municipal Social Services. A letter is then sent to the Home describing the breach of Regulations and stating that the matter must be attended to within a certain period of time. If the problem is small the Home must only notify the Department in writing of the correction, but when there has been a major problem, considerable consultation with a departmental inspector may be necessary before a re-inspection takes place. If the difficulty is rectified to the satisfaction of the inspector, a license to operate is recommended.

The Associated Homes for Special Care specified in a recommendation that "after review or inspection has been carried out, the program review be received by the Home, including among other comments:

1. pertinent recommendations
2. realistic time frames for compliance with such recommendations"

Throughout the meetings with representatives of facilities and organizations this was a common theme.

1.4.19 The Task Group recommends the development of a manual describing guidelines for inspections, copies of which should be distributed to facilities, in order to ensure that there is no question about the expectations or requirements of licensing inspections. In addition, procedures should be developed to provide Homes with a detailed report of each inspection made.

Regardless of how serious the violation, or the failure to comply with the terms and conditions of the license, the Department of Social Services or any other department or agency of government does not actually have the authority to close a facility. According to Section 21 of the Homes for Special Care Act, the maximum fine for violation is $100 for every day the violation continues or a maximum of thirty days imprisonment. The Task Group recommends that:

1.4.20 The Department of Social Services immediately propose an amendment to the Homes for Special Care Act and Regulations which would give some department of Government or agency the power to close a Home for Special Care when the Home fails to comply with the terms of the Act and Regulations.

(f) Consultation

Specialized and skilled staff are provided by most provinces to assist Homes in developing programs and services. Nova Scotia currently utilizes its inspection and licensing staff for this purpose, except in the areas of nutrition and activity planning.

There was continuing discussion among the Task Group members about the

advantages and disadvantages of separating these three functions. In those provinces we visited this subject was explored with staff who represented both the non-integration and the intergration of these functions.

In other areas of the Department of Social Services such as Services to the Mentally Handicapped (Children and Adults), specialized program consultative staff already exist. Given the growth in the senior population, the number of residents in Nursing Homes and Homes for the Aged, and the ever increasing need for changing and developing programs, the Task Group recommends that:

1.4.21 As part of current re-organization plans, the Department of Social Services consider establishing a specialized team of consultants in such areas as Pharmacy, Nursing, Dietetics, Physiotherapy, Occupational Therapy and Leisure/Recreation Programs to provide consultation both to the Department and to the Homes for Special Care.

PART 2

SERVICES TO MENTALLY HANDICAPPED CHILDREN

2.0 SERVICES TO MENTALLY HANDICAPPED CHILDREN

For the most part, the Report of the Working Group on Services for Mentally Handicapped Children stands separate and apart from the other Working Group reports, all of which deal with services to adults. Only the population projections for children who will require adult placement upon reaching the age of majority have implications for the services for mentally handicapped adults.

The Working Group on Mentally Handicapped Children was mandated to review and evaluate current municipal, provincial, and private sector service roles and responses, both provincially and regionally, identify service needs and gaps; and develop recommendations for the next six years. In its report the Working Group placed emphasis on services to mentally and emotionally handicapped children. Services to other groups of children such as young offenders, the learning disabled, and the physically disabled are only mentioned in the report.

This section of the Task Group report is a summary of the Working Group report with the addition of comments by the Task Group.

HISTORY

Prior to the 20th Century, the care and upbringing of handicapped children was generally the responsibility of their families and relatives, charitable organizations, or the churches. Early efforts to provide some care to mentally handicapped children often resulted in children being mixed with adults with various types and levels of disability. The emphasis was upon mass provision of long-term care in a "house of refuge" from the world.

With the growth of knowledge about mental and physical disabilities, and increased sensitivity to the life situations of persons with such disabilities, this century has seen the beginnings of the separation and specialization of services for each group of people, and the assumption of responsibility by the state for the provision of care and services. In Nova Scotia, the League for the Protection of the Feeble Minded, later called the Mental Hygiene Society, lobbied government to form a

committee to study the problems and needs of the mentally handicapped. Along with several other organizations, the Medical Society, the Women's Council, the I.O.D.E. and the Catholic Women's League, it was instrumental in establishing one of the earliest services and facilities for mentally handicapped children.

In 1916 the first class of handicapped children was established in Halifax. This initiated an auxiliary movement which had considerable influence on future care and training of handicapped children. In 1918 the I.O.D.E. opened a cottage in Halifax for feeble minded girls. This small institution rendered invaluable service during its decade of existence in focusing public interest upon the pressing nature of the problems. It was in the I.O.D.E. Home, the Home of the Guardian Angel and the Monastery of the Good Shepherd that the first attempts were made in Nova Scotia to provide for the training of the handicapped.

In 1927, a Royal Commission recommended the establishment of the Nova Scotia Youth Training Centre. The first building was constructed in 1929 and the first children were admitted in 1930. By the Fall of 1948 discussions had advanced to the point where draft plans were drawn up for a duplex type of building to house lower functioning boys and girls. This building was completed in 1950 and the first students were admitted in 1951.

In the Fall of 1954, the Nova Scotia Association for the Help of Retarded Children was formed. Later, four branches were added to this organization and in 1958 the Provincial Association was established.

In 1973, the Department of Education approved Regulation 7(C) which made educational instruction for physically and mentally handicapped children mandatory. Other programs and services quickly developed including respite care, units at the School for the Deaf, units at the School for the Blind, and units at the Nova Scotia Hospital. These new programs had, and continue to have, a profound influence on programs operated by the Department of Social Services and on the quality of programs delivered to mentally handicapped children.

CURRENT SITUATION

In the Province of Nova Scotia at the present time, there are three principle providers of services to mentally handicapped children: the Department of Social Services, the Department of Education, and the Department of Health.

(a) Department of Social Services

This Department operates five institutional training centres for mentally handicapped children: the Nova Scotia Youth Training Centre in Truro, and the four Children's Training Centres located in Sydney, Pictou, Dartmouth and Digby. It also provides a specialized foster care program throughout the province whereby mentally handicapped children are placed and supervised in selected foster home settings and a small in-home support program. Through a purchase of service agreement, the Department of Social Services has also arranged with one of the Nursing Homes to have care and training provided to mentally handicapped children requiring specialized nursing care or observation.

It should be noted that the Department's other generic children's programs are also open to those mentally handicapped children who are able to participate.

(b) Department of Education

Through District School Boards the provincial Department of Education operates a wide range of specialized school programs, both for the "educable" mentally handicapped child and the "trainable" mentally handicapped child. Mentally handicapped students are expected to attend school between the ages of 6 and 16, but may attend between the ages of 5 and 21. Emphasis in the educational setting is upon the student progressing at his or her own individual level; that level is determined by structured assessments.

The aim of the educational program for the mentally handicapped is the development of personal, social and academic skills, enabling the student to take a

useful and productive place in society. At present there are over 3,000 special education students in Nova Scotia schools.

(c) Department of Health

Services to mentally handicapped children through the provincial Department of Health are primarily provided through the Nova Scotia Hospital, the Izaak Walton Killam Hospital for Children, the Atlantic Child Guidance Clinic, and related clinics and agencies.

In conjunction with these three departments, various private agencies or services also endeavour to provide select services to mentally handicapped children.

TRENDS - NOVA SCOTIA

With the increase in community support services to mentally handicapped children and particularly the development of educational services in various communities throughout the province, the need for institutional beds for children has decreased over time. This trend is particularly visible in those facilities operated for the care or training and education of mentally handicapped children.

Over the last five years there has been a 22 percent decrease in the utilization of the Nova Scotia Youth Training Centre. This trend will probably continue in the next six years and will ultimately result in the need to either close, or use for other purposes, one or more of the buildings on the campus of the Nova Scotia Youth Training Centre.

An even more significant decrease is occurring in both the admissions and population of the Children's Training Centres, as fewer children are requiring their services. Projections for Children's Training Centres inclusive of 1989 show this trend will continue.

In parallel with trends elsewhere, the number of children in the foster care program has decreased over the last five years. Intake and discharge projections indicate that the demand for full-time foster care for mentally handicapped children will continue to decrease over the next six years.

The philosophy underlying the development of services for mentally handicapped children in Nova Scotia over the last few years has been one of maintaining children in the community and in their own homes wherever possible. To consolidate this approach, the Department of Social Services has started an in-home support program for mentally handicapped children. The purpose is to develop individualized programs for children which enable them to remain in their own homes and in the community.

INTER-PROVINCIAL COMPARISON OF TRENDS

In reviewing the major needs in service over the last six years, and projecting into the next six years, it is noted that the service responses of the Province of Nova Scotia to mentally handicapped children are definitely in line with current thinking. The emphasis on community placement facilities, the decline in institutional populations, the lowering of care level profiles in institutions, the development of a more extensive community-based support service system, and an increasing emphasis on early identification and intervention with mentally handicapped children; these are all movements in the system which compare favourably to any other province in Canada.

RECOMMENDATIONS

The Working Group on Services to Mentally Handicapped Children did a thorough review of current service needs and gaps, and proposed a plan for the direction of services during the next six years. In developing their proposals, the members used an inventory of services from pre-natal, through infancy, preschool, and school-age up to 18 years. Their recommendations were grouped under five general headings:

- Review of mandate and terms of reference of existing services
- Research and Planning
- Creation of New Services
- Public Education and Access
- Facilities and Staff

The general thrust of their recommendations is toward the development of a system of community and in-home support services for mentally handicapped children (utilizing resources which will become available as the need for the Children's Training Centres declines). A list of the Working Group's recommendations together with a schematic representation can be found in this report on pages 51, 52, 53 and 54 respectively. With the exception of the recommendation addressed in the following paragraphs, the Task Group supports the Working Group's recommendations.

The primary issue examined by the Working Group was the future of the Children's Training Centres. Based on the projected admissions and discharges for the next six years the Department will have to explore the future utilization of two of these facilities. The Working Group indicated that the Centres in Pictou and Sydney are most likely to be the first two affected by the population decline. If the projected trend continues, at the end of the six years the Department will need to re-examine the use of the other two Children's Training Centres.

As was mentioned previously, the Nova Scotia Youth Training Centre is also experiencing a decline in admissions. The Working Group noted that one or more buildings at the Centre may be available for other use within the next few years.

The Task Group recommends that:

2.1.1 A total review of the facilities serving mentally handicapped children be initiated immediately by the Department of Social Services and a plan developed for their future use.

In their report the Working Group addressed the need for a specialized treatment facility for emotionally disturbed children. They recommended that the Dartmouth Children's Training Centre be converted for this purpose.

The Task Group believes that the redirection of the Dartmouth Children's Training Centre should not depend solely on the need for a facility for emotionally disturbed children. In fact, the issue of a facility for emotionally disturbed children is separate and apart from the current trends in Children's Training Centres. It is related to the broader area of the mainstream services offered for children by the Department of Social Services. The Task Group, therefore, recommends that:

2.1.2 The Department of Social Services include within any review of Children's Services a further examination of a facility for emotionally disturbed children both in terms of need and location.

RECOMMENDATIONS OF THE WORKING GROUP ON SERVICES TO MENTALLY HANDICAPPED CHILDREN

1. The Working Group recommends that the Dartmouth Children's Training Centre be converted into a facility for difficult to manage "emotionally disturbed," mixed diagnosis children, aged 12-16 years. It is further recommended that the Departments of Health and Education participate with the Department of Social Services in the creation and implementation of this new service. As a consequence of identifying the Dartmouth Children's Training Centre for this purpose, a number of other recommendations logically follow.

2. It is recommended that the existing residents of the Dartmouth Children's Training Centre and their families be assessed to determine whether they would be better served in their own homes, in foster home placements, or in one of the other three Children's Training Centres.

3. It is recommended that the special foster care program for mentally handicapped children be integrated into the Family and Children's Services foster care caseload.

4. It is recommended that as populations in Children's Training Centre decline, the plan for converting or phasing out centres as outlined in the six year plan be implemented.

5. It is recommended that the Nova Scotia Youth Training Centre continue to monitor population levels and manage fluctuations in populations by scaling up or down as appropriate, as outlined in the six year plan.

6. The Working Group recommends that existing services continually review their mandates and terms of reference in order to increase their quality of service and quality of life of handicapped children.

7. The Working Group recommends that a research and planning component be an essential aspect of service delivery, providing direction and continual updating of methods and techniques.

8. The Working Group recommends that in addition to the conversion of the Dartmouth Children's Training Centre to the special purpose indicated, five specialized foster homes be established, one in each of the Department's five regions, with mandate and terms of reference as outlined in the six year plan.

9. The Working Group noted that knowledge of access to the Departments of Health, Education, and Social Services was limited, especially in the outlying regions of the province. It is therefore recommended that a greater emphasis be placed on publicizing existing services and on enabling better access to services by Nova Scotians.

SIX YEAR PLAN OF ACTION

ITEM	YEARS					
	1	2	3	4	5	6
Formalization of current In-Home Support Programs	X					
Increase in special day care spaces	X					
Extension of infant stimulation programs	X	X				
Early identification and contact with new parents	X	X				
Mobile dental clinics	X	X				
Extension of special therapy services	X	X				
Extension of vocational orientation and placements	X	X				
Development of planning model	X	X				
Extension of sex education and recreational/ leisure skills training	X	X				
NSYTC population review	X	X	X	X	X	X
Review of the Admissions Committees Terms of Reference	X	X				
Annual children's assessments	X	X	X	X	X	X
Parental survey re: CTC residents	X	X		X		
Conversion of the Dartmouth CTC	X	X	X	X	X	X
Provision of information on content and assessing services	X	X	X	X	X	X

	YEARS					
	1	2	3	4	5	6
Identification and development of role of regional planners	X	X	X	X	X	X
Pilot professional foster care program in each region of the province		X	X	X	X	X
Review of the status of Palmeter's Children's Unit		X				
Complete review of the role, function, and current need for NSYTC			X			
The phase-out plan as outlined in the Working Group Report be followed	X	X	X	X	X	X
Continual review of service mandates and terms of reference of all services	X	X	X	X	X	X
An evaluation component be built into each service	X	X	X	X	X	X

PART 3

SERVICES TO MENTALLY HANDICAPPED ADULTS

3.0 SERVICES TO MENTALLY HANDICAPPED ADULTS

For the past decade, in Nova Scotia and across North America, the development of residential and support services for the mentally handicapped has been guided by the principle of normalization. Normalization has the following emphasis: the integration of the mentally handicapped into a variety of community living settings; the provision of a broad array of community-based support services; a gradual policy of deinstitutionalization of mentally handicapped persons from large, often remote, institutional facilities; and a rehabilitative rather than custodial orientation within institutions to ensure that persons are moved as quickly as possible to community alternatives.

In Nova Scotia the acceptance of this principle has led gradually to the development of more normal living environments and day programs. Approximately twenty percent of handicapped persons now residing in specialized residential environments, live in group homes, developmental residences or supervised apartments. Community and adult vocational work centres provide approximately 1,000 spaces for mentally handicapped persons living at home and in community residences. Municipal recreation departments and continuing education services are gradually assimilating the mentally handicapped into their programs. Most institutional facilities are progressing towards goal-related rehabilitative programs rather than simply providing personal care.

NATIONAL TRENDS

A study of the service developments in the other nine provinces illustrates that the general directions taken in the last decade in Nova Scotia are consistent with national trends.

All provinces appear to have adopted a policy of deinstitutionalization in the past decade; all have been proceeding to varying degrees with the development of community-based residential alternatives; and all have increased the quantity, quality and variety of day program options. Most of the other provinces have

made efforts to isolate the mentally retarded from those experiencing post-psychiatric difficulties. Most provinces have also been moving rapidly during the past decade to find community placements for higher functioning mentally handicapped persons, and are now collectively facing the more difficult task of providing community-based services for severely mentally retarded persons. Other provinces are also finding that their remaining institutions are caring for a more severely handicapped population and thus while numbers are down, the demand for higher staffing ratios has increased.

While there has been significant movement out of institutions to group homes and developmental residences, most other provinces are experiencing a "bottleneck" effect at the group home level and are seeking innovative ways to find alternative longer term community placements. A study of per diem rates in both institutional and community-based facilities would appear to place Nova Scotia on the lower end of the relative cost scale.

CURRENT STATUS OF SERVICES IN NOVA SCOTIA

The Report of the Working Group on Mentally Handicapped Adults describes in detail the nature of the current delivery system of residential and vocational services for the mentally handicapped, including the strengths and weaknesses as perceived by the authors and by community submissions, a detailed analysis of demands for services on a comparative basis over the past four years, and a comparative utilization study of residential placements by region.

The report notes that there are currently 1,465 spaces (beds) for mentally handicapped adults in specialized Homes for Special Care. This includes three Regional Rehabilitation Centres, nine Adult Residential Centres, twenty-one Group Homes and ten Developmental Residences. In addition, approximately 100 clients are placed in unlicensed supervised apartments. In terms of day program availability, there are approximately 800 spaces in 30 vocational workshops across the province.

Most institutional services are operated by the municipal level of government and most community-based residential and workshop services are operated by private non-profit corporations.

Community-based residences tend to have homogenous populations (persons with similar problems and needs) while institutional populations have a mix of mentally retarded individuals and persons with post-psychiatric difficulties.

CONCLUSIONS AND RECOMMENDATIONS

The major emphasis in the future should probably be for some type of well organized, mandatory regional planning mechanism. The Working Group suggests that with such a relatively small population of mentally handicapped persons, with diverse and specialized needs, an organizational entity larger than many of the individual municipal units would be required in order to ensure effective and efficient service planning and delivery.

This report notes that the current per diem rate system does not provide an incentive for facilities to discharge their higher functioning residents. They may not be able to replace these residents immediately, and will therefore realize a revenue shortfall. In addition, higher functioning residents may be replaced by lower functioning residents who will require more care, thus creating a need to increase staffing.

Many of the submissions expressed concern with "bottlenecks" in the system, particularly at the level of community based residences. They also pointed out that there is a perceived need for more long term "maintenance" Group Homes or unlicensed residential situations which would serve persons who are no longer benefiting from the training environment of existing Group Homes and Developmental Residences.

The need for more in-home support services was also noted, along with the observation that better case management and follow-along service is needed at the local level if more mentally handicapped persons are to live in their own homes, in unlicensed supervised apartments, or in specialized foster homes.

The Working Group study suggests that the most pressing demand for specialized service development in the immediate future is for services for severely mentally retarded younger persons.

The recommendations of the Working Group relating to regional planning, funding concerns, the assessment of residents of Residential Care Facilities, classifications and assessments, and in-home support programs are addressed in other sections of this report. Included here is a composite view and comment on the remaining recommendations.

GUIDELINES

Over the past decade the general direction taken by the Department of Social Services in the development of services and programs for the adult mentally handicapped has been consistent with the principle of normalization. There is not, however, a clearly written statement of principles for service and program development within the Department which can be disseminated to service providers, consumers, and interested groups or organizations.

In order to ensure that all levels of government and service providers in the province are operating with a common sense of direction, a statement of principles must be clearly defined. It is, therefore, recommended that:

3.1 The Department of Social Services prepare a policy statement entitled "Principles Relating to the Planning, Development, and Delivery of Services for the Mentally Handicapped in Nova

Scotia" to be disseminated to all groups, agencies, and municipal units responsible for providing and developing services for mentally handicapped adults.

RESIDENTIAL REQUIREMENTS

At present there is an inequitable distribution of residential options throughout the province. Metropolitan Halifax-Dartmouth in particular is far ahead of the other regions. The Working Group's findings suggest that the 1,500 licensed and unlicensed residential spaces in facilities specifically designed to serve the mentally handicapped should be adequate to meet the projected needs in the province until 1990. In order, however, to ensure consistency with the guiding principles for service development, and an even distribution of residential alternatives across the province, a redistribution of the different types of residential spaces available should take place within each of the five regions of the province over the next five years. This would have a major impact in all regions except Halifax. The closure or reduction in size of some of the existing Regional Rehabilitation Centres and Adult Residential Centres is likely to occur. In addition, vocational workshops and other community support services would be affected, and may have to be expanded or developed to meet the day program needs of residents in newly established or expanded community based facilities.

The Working Group considered a realignment of residential services as both desireable and possible within the present level of provincial funding. The Task Group supports this view and recommends:

3.2 That the Department of Social Services establish proposed objectives for residential services for the mentally handicapped to be achieved by the year 1990.

STANDARDS

(a) Staff Complements

The Working Group concluded that current staff complements in Regional Rehabilitation Centres are adequate. Only minor adjustments or reallocation of staff resources are required to meet the staffing needs for the next six years. Much the same situation exists in Group Homes and Developmental Residences, although nominal adjustments may be necessary to meet particular circumstances.

Major disparities do exist, however, in Adult Residential Centres, where staff-to-resident ratios vary from one facility to another. These disparities are particularly evident in the category of professional and program support staff, and stem from the traditionally custodial origins of these facilities.

In the absence of guidelines and staffing standards such disparities will continue to exist. It is, therefore, recommended that:

3.3 The Department of Social Services develop staffing guidelines for all staff groupings in facilities serving the mentally handicapped and implement them on a gradual basis over the next five years.

(b) Staff Training

Usually staff employed in residential services for the mentally handicapped enter employment with no previous specialized training or experience. Few facilities have training budgets which allow for comprehensive staff training programs with which to complement skills learned on the job.

With co-operation from the staff of the facilities, the Department of Social Services has developed a curriculum for a Developmental Workers Course. This course which has not yet been implemented, recognizes the need to train staff so they can better help residents achieve greater independence.

In order to facilitate in-service training for present staff and ensure trained staff are available in the future, it is recommended that:

3.4 Staff training be recognized as a vital component of each facility's budget and be included in the per diem rate. Such funding should be based upon the minimum standards of education and experience for staff which should be established by the Department of Social Services in co-operation with representatives of the administrations of facilities.

(c) Salaries

The Working Group on Services to Mentally Handicapped Adults felt that there should be some standardization of salary scales in group homes and developmental residences to bring them in line with salaries paid to staff in the larger institutions, and that standardization be implemented on a gradual basis. The Task Group recognizes the salary differential in similar facilities but believes the Province should not be involved in establishing salary levels in facilities which are not operated by the Province.

(d) Mixed Population - The Working Group on Services to Mentally Handicapped Adults expressed several concerns about the mixing of the elderly, post-mentally ill and mentally retarded adults. One of the major areas of concern was the Residential Care Facilities where these population groupings co-exist without proper programming or support. The particular difficulties inherent in these settings are addressed in Part 5 of the Task Group report and are, therefore, not repeated here.

Other problems of population mixing, in relation to Adult Residential Centres in particular and to Regional Rehabilitation Centres to a lesser extent, are as follows.

- residents are mixed in living space without attention to age, infirmity, disability or handicapping conditions leading to problems in

programming and compatibility,

- usually where residents are mixed there is no separate or special programming directed to the needs of each group. For the mentally handicapped group this means the potential for training, rehabilitation and growth toward a higher level of functioning is lost.

The Task Group supports the belief of the Working Group that effective programming will not occur until the residents are separated into compatible groups and specific programs are designed to meet their needs. The Task Group, therefore, recommends that:

3.5 By September 30, 1985 the Boards of Management of those facilities where disparate populations are mixed be required to establish an action plan to provide separate living space and programming for each group.

LEGISLATION

The Working Group was concerned with the lack of legislated program standards. This situation was seen to present difficulties to licensing and program staff from the Department in their efforts to assess facilities and programs, and to ensure compliance with Departmental guidelines. Guidelines which are without the force of the law have on occasion been ignored by the facilities, particularly Adult Residential Centres. It is, therefore, recommended that:

3.6 A review of the guidelines for individual program planning and delivery be undertaken and recommendations for the inclusion of basic program standards in legislation be made to the Legislative Review Committee of the Department.

ADVOCACY

Briefs submitted by advocacy organizations suggest that mentally handicapped adults without close family ties are unable to cope with the bureaucratic structure of the service system. It was suggested that they should have client advocates to represent their interests in classification related matters; in monitoring the services provided to them regardless of where they may be residing; and to provide them with a "friend" from outside the service delivery system. While small programs providing "citizen advocates" exist in some of the larger population areas, there is no organized approach on a provincial basis to respond to this particular need. It is the opinion of both the Working Group and the Task Group that the entire matter of advocacy and specifically the identificiation and "matching" of advocates, belongs with advocacy groups in the private sector.

VOCATIONAL SERVICES

The number and distribution of spaces for vocational services is such that both at present and in the future they may not be available in sufficient numbers in the areas where they are most needed. It is important, therefore, to co-ordinate the development of community residential facilities with the availability and accessibility of workshops.

A survey of existing vocational services, with projections to 1990, indicates that the Halifax-Dartmouth area and Shelburne County are in the most immediate need of additional vocational services. In any expansion of services, these two areas must be given priority.

Both the Working Group and the Task Group are of the opinion that community-based residential facilities should not be developed unless adequate day programming is available. Lack of such programming can lead to problems both for residents in the facilities and for the communities in which they are located. In

addition, the rehabilitative or training process may be undermined or blocked altogether by these inadequacies and gaps in service. Accordingly, it is recommended that:

3.7 The Department of Social Services allocate capital funds on an annual basis for the expansion of vocational services relative to the establishment of new community based residential facilities throughout the Province.

PART 4

THE PHYSICALLY DISABLED

4.0 THE PHYSICALLY DISABLED

The major focus of the Task Group and its related Working Groups has been the elderly and the mentally handicapped; this report reflects that focus. There is, however, a small group of individuals in our Homes for Special Care whose needs have been addressed only peripherally during the course of the Task Group's work. That group, representing less than one percent of the population of our Homes for Special Care, is composed of young physically disabled persons who, because of accident or chronic disease, require intensive personal care. These individuals are neither senile, confused nor mentally handicapped, but are often attributed with these characteristics because they live in Homes for Special Care alongside elderly or mentally handicapped persons. Only one small community-based facility exists exclusively for the care of the physically disabled.

The Task Group is very aware of the needs and concerns of the younger physically disabled population in Homes for Special Care, but it was not possible within our mandate to undertake an indepth study of the needs of this group. Although many of the comments and recommendations made throughout the report are applicable to the younger physically disabled residents, it is in recognition of their special needs that the Task Group decided to include a separate brief note of their particular concerns.

During the course of our study one individual and four organizations representing the physically disabled submitted briefs and met with the Task Group. Most concerns were in two major areas:

- the need for a broader range and greater availability of in-home support services for disabled persons so that they can be maintained in their own homes and avoid institutionalization.

- for young disabled persons who must enter Homes for Special Care, the provision of programs and services which enable them to achieve a maximum degree of independent functioning, and

ensure the maintenance of their self esteem. The overall objective would be to return the individuals to the community wherever and whenever possible.

Within the context of this second area, the suggested direction for programming in Homes for Special Care is a rehabilitative one.

The following list details several of the specific concerns which were expressed to the Task Group:

1. The scheduling of the activities of daily living prevents or makes it difficult for residents in Homes for Special Care to maintain independence. Emphasis was placed on the value of self-help in an institutional environment in order to maximize physical functioning and allow residents to become involved in decisions affecting their lives.

2. An information system for residents of Homes for Special Care is needed so that upon admission, they are aware of their rights as residents. There also needs to be a mechanism for residents to make known their complaints and concerns.

3. Residents need more privacy during both the activities of daily living and visits from family and friends.

4. The environment for the younger physically disabled could be enhanced by providing both living space and programming suitable to their needs.

5. Changes need to be made in the comforts allowance and Family Benefits provisions so that physically disabled persons can move more easily from a large institutional setting to smaller

community-based residences, and from there to more independent living situations in the community. Current provisions do not permit sufficient savings from earnings or comforts allowances to purchase items such as furnishings for an apartment, which are needed for a more independent living situation.

Obviously some of the concerns expressed can be addressed without lengthy study, therefore the Task Group recommends that:

4.1 The Department of Social Services should immediately identify facilities where there are several younger physically disabled residents, and, in co-operation with the Home and those residents, undertake a review of their particular situations. The objective would be to enhance their quality of life by instituting programming, environmental and other changes wherever and whenever possible.

The Task Group is aware that the Minister and staff of the Department of Social Services have been involved in continual individual dialogues with community groups and organizations representing physically disabled consumers in Homes for Special Care. Since it is necessary to adapt programs, services and facilities in line with progressive changes in the understanding, knowledge and perceptions of the physically disabled, the Task Group suggests that a detailed examination of the needs of the physically disabled in Homes for Special Care be initiated. It is recommended therefore that:

4.2 The Department facilitate the review of the longer term needs of the younger physically disabled populations in Homes for Special Care in order to enhance their

quality of life, by bringing together representatives of consumers, the Homes for Special Care, the municipalities and the community at large.

PART 5

RESIDENTIAL CARE FACILITIES

RESIDENTIAL CARE FACILITIES

In the Homes for Special Care Act, 1976 and its accompanying Regulations[2], the definition of Residential Care Facilities includes community based facilities such as Group Homes and Developmental Residences for the adult mentally handicapped. In this section of the report, however, we are addressing only those facilities which traditionally have been known as "boarding homes".

Residential Care Facilities house individuals who are covered by a variety of programs and services. For this reason the Task Group has chosen to address these facilities separately by combining major points drawn from several of the Working Group Reports. This special treatment enables us to address specific issues and concerns but does not preclude other parts of this report also being applicable to Residential Care Facilities.

Boarding homes were the forerunners of Residential Care Facilities. They were small, privately owned and operated, community-based homes offering minimal supervisory services to adults regardless of age, functional level or handicapping condition. The boarding homes varied in age, size and condition, and until 1965 were not licensed or regulated. When the Boarding Homes Act came into effect in that year, the Department of Social Services acquired responsibility for licensing and for regulating standards for an assorted population of elderly, mentally retarded or post-mentally ill adults, all of whom where housed together in these facilities. This Act was subsequently incorporated into the Homes for Special Care Act in 1976.

Over the years Residential Care Facilities have been unique entities within the Homes for Special Care system. Most of them have remained small, averaging 17 residents each, with a range from 4 to 78 residents. Unlike most of the other larger Homes for Special Care, they have continued to contain a mixed population within each individual facility. The majority of Homes are owner operated and generally offer few programs for residents. They also differ from other facilities in that approximately 50 percent of their residents are private paying and 57 of the 60 facilities are operated for profit.

RESIDENTIAL CARE FACILITIES

Today[2] Residential Care Facilities contain a total of 1032 beds. Forty-eight percent of the residents are 65 years of age or over, 40 percent are post mentally ill, 10 percent are mentally retarded and 2 percent are in the facilities for other reasons. The mix of ages and handicapping conditions varies from one facility to the other.

INTER-PROVINCIAL COMPARISONS

Few useful or valid comparisons can be drawn between Residential Care Facilities in Nova Scotia and similar institutions in other provinces because the structure of services and the nomenclature of the facilities and the classification of the population served is variable from place to place. However, all eight of the provinces surveyed do have some small community based facilities. In New Brunswick, Prince Edward Island, Newfoundland, Ontario, Alberta and British Columbia the facilities are licensed by the province, while in Manitoba licensing is dependent upon the auspices and population served. Saskatchewan operates a Boarding Out Program under the Department of Health in which homes caring for six or more residents are approved but not licensed. The criteria for licensing - for example, the minimum number of residents -differ from province to province.

CONCERNS AND RECOMMENDATIONS

Those factors which make Residential Care Facilities unique within the Homes for Special Care System give rise to a number of concerns. These concerns are recounted briefly here and are accompanied by appropriate recommendations[3].

(a) Mixed Population

The outstanding concern expressed to the Task Group and Working Group on Standards of Care by the operators of the facilities, residents, and other groups and organizations was that persons who are elderly, mentally retarded or post-mentally ill are mixed together in each home. The current resident population was aptly described in the report on Standards of Care as a "hodgepodge".

The existence of this mixed population is significant because it affects not only the residents and the internal operation or functioning of the facility, but may also have an impact on the surrounding community. For example, these facilities were not designed or staffed to provide more than minimal supervision of the residents' daily living, consequently, they cannot generally provide the necessary supportive care and programs required by post-mentally ill or mentally retarded residents. In fact, there is only minimal programming in Residential Care Facilities. This means that inactivity and boredom are common. In some areas residents wander about the community, sometimes getting into difficulties. To compound this problem community support programs for residents are also inadequate in most areas of the province.

Another problem that arises in mixed populations is that elderly residents may be fearful of younger residents who have behavioural problems. These younger residents, on the other hand, have no opportunity to channel and utilize their energies in constructive ways.

The Working Group on Services to Mentally Handicapped Adults was particularly concerned about the younger mentally handicapped residents of these facilities. It felt they might be more suitably placed either in specialized services for the mentally handicapped or in independent living situations in the community. Unfortunately, the principle of normalization tends not to be emphasized in Residential Care Facilities.

In relation to post-mentally ill residents, the Task Group was told that the lack of supportive programming both in the facility and in the community often means that the resident does not become stabilized in a community setting after discharge from psychiatric hospital. Although occasional follow-up visits to out-patient psychiatric clinics do occur, the clinics are not designed to provide the degree of continuous support many residents need in order to function in a community setting. The lack of support often results in the resident returning to hospital frequently for adjustments of medication and further therapy. In addition,

some operators of Residential Care Facilities were particularly concerned about their lack of training and skill in managing post-mentally ill residents with behavioural problems. Their opinion was that these residents should not be housed in the same facility as the elderly and adult mentally retarded persons.

Obviously there is room for change in the Residential Care Facility system, and that change must reflect the needs of the individuals served by the system. However, one of the difficulties in determining the needs of the population is that we have an inadequate knowledge of the individuals comprising the resident population. Very little planning can take place until we study the population thoroughly. It is recommended, therefore, that:

5.1 The Department of Social Services undertake a complete and systematic review of the population of Residential Care Facilities, to make immediate adjustments, where possible and to establish the foundation for future changes.

The solution to the current population mix is a long term one. The Residential Care Facilities are the one major group of institutions in which we continue to allow extensive intermixing. Only by changing our future requirements for new facilities and designating specific populations for specific facilities will this situation be changed. With this in mind it is recommended that:

5.2. Guidelines for the future development of Residential Care Facilities be established which, as a precondition for ministerial approval to proceed, require the owner/operator to submit a statement of purpose and programme regarding the population the facility is to serve.

(b) Classifications and Assessments

Only publicly assisted residents placed in Residential Care Facilities are classified prior to placement. This means on admission that we know very little about

approximately fifty percent of residents who pay privately. Indeed, persons may be admitted who require more care than a Residential Care Facility can provide.

A problem occurs when, upon review of a facility, it is discovered that a resident is inappropriately placed. Any intervention to have the resident moved to a more appropriate care setting tends to cause trauma for both the resident and the family for several reasons. The two most common ones are as follows:

- the resident has settled into the facility, has become familiar with staff and routine, (as has the family) and does not wish to move

- the resident may have chosen the facility based on the per diem rate or his or her care need at a particular time. Rates in Residential Care Facilities are generally much lower than those in Homes for the Aged or Nursing Homes. For a privately paying resident the move to a more expensive facility usually means that funds are more quickly depleted thus hastening reliance on public support for maintenance costs.

These problems could be avoided by requiring the classification of all residents applying for admission to Residential Care Facilities. Two of the Working Groups, Standards of Care and Classifications and Assessments, examined this matter but reached different conclusions. The Standards of Care Group recommended that all persons, whether privately paying or publicly supported, be classified prior to admission; the Group on Classifications and Assessments recommended that admissions be monitored and that penalties be imposed on Home operators when they make inappropriate admissions. For the latter group the crux of the issue was the individual's freedom to choose the service or facility for which he is paying. The other Working Group believed that ensuring proper placement was of primary importance.

The Task Group perceives this issue as important but not occurring with such frequency or in such magnitude that it is a pressing matter requiring immediate

attention. Neither of the two recommendations has been adopted at this time. A decision on an appropriate course of action should be held in abeyance pending both the complete review of the resident population of Residential Care Facilities and also a decision on the classification of all persons requesting admission to Homes for Special Care.

(c) Safety

A number of recommendations on safety were made by the Working Group on Standards of Care. Several concerns form the basis of these recommendations: the age and design of buildings; the remoteness of many of them from fire stations; lack of conformity to fire standards; the lack of mobility of residents housed on second and third floors; and the limited availability of staff to ensure the safety of residents in an emergency.

Although the fire safety standards have been upgraded in these facilities and they meet the standards set for them by the Fire Marshall, many of the buildings are old wooden structures and for that reason alone present greater fire hazards than newer, more modern buildings. The Task Group feels that measures should be taken to ensure that residents have every possible chance to escape in the event of a fire. With this in mind they have made the following three recommendations:

5.3 Residents who are dependent on mechanical aides for ambulation should not be accommodated above the ground floor.

5.4 Fire drills should be held every three months in a Residential Care Facility.

5.5 At any one time the staff to resident ratio in a Residential Care Facility should not be less than 1:15 or a major fraction thereof.

(d) Space and Size

Residents of Homes were strong advocates for the privacy afforded by single or double rooms. In Residential Care Facilities it is not uncommon for bedrooms to house four or five people. Our current legislation allows a maximum of four residents per room and requires a minimum of one hundred square feet for the first resident and fifty feet for each additional resident. Since these space requirements allow little or no room for privacy, for consideration of personal differences, or for personal belongings, we make the following recommendation:

5.6. The current legislated space requirements for bedrooms in Residential Care Facilities be retained but the legislation be changed to establish a maximum of two residents per bedroom.

Residential Care Facilities started as small, home-like community-based settings. The primary emphasis in the beginning was to provide or simulate a home-like environment for persons who were unable to remain in their own homes, and who required minimal supervision and help with the activities of daily living. In an effort to preserve the advantages of the small homelike environment, the Working Group on Standards of Care recommended that the licensed capacity of a Residential Care Facility not exceed twenty residents.

THE FUTURE

In reviewing Residential Care Facilities, the Task Group is of the opinion that the role, function and structure of this group of facilities within the total care system should be reassessed. Most of the recommendations which have been made will meet immediate needs and concerns. However, where these facilities fit, if at all, within a system designed to meet future care needs and provide facilities for the elderly, the adult mentally retarded and post-mentally ill, depends on the direction taken for each of these population groupings over the next decade.

It may be speculated that the demand for Residential Care Facilities will decrease, as in-home support services and home care services for the elderly become more available and offer a wider range of services, as we develop a more sophisticated and comprehensive community-based service delivery system for the mentally retarded, and as we make progress in the development of a community support system for the post-mentally ill. In fact, a decrease in the number of facilities and residents is already noticeable. On May 1, 1976, there were 93 Residential Care Facilities with 1781 beds. On May 1, 1984, there were 60 such facilities with 1032 beds. With all this in mind, the Task Group's final suggestion related to Residential Care Facilities is as follows:

5.7. Upon completion of a total review (Recommendation 5.1) of the population of Residential Care Facilities and the establishment of future program directions for each homogeneous part of the resident population, the Department of Social Services should decide what role and function, if any, these facilities will have in future in the total care system. If they are to continue, new guidelines and directions for their operation should be developed. If they do not have a future role, a plan for their systematic phasing-out should be developed.

PART 6

COMFORTS ALLOWANCE

6.0 COMFORTS ALLOWANCE

Comforts allowance is a sum of money provided on a monthly basis to publicly supported residents of Homes for Special Care. It is for the resident's sole use for the purchase of such things as magazines, newspapers, cosmetics or other items which are not ordinarily provided as part of the care component of the Home.

CURRENT SITUATION

Provincial legislation establishes the parameters for the maximum cost-shareable comforts allowance and accumulation. Comforts allowance is paid to residents through the municipal unit of settlement. For residents in all homes, except Regional Rehabilitation Centres, the municipality determines the amount of comforts allowance to be paid and is reimbursed by the province at a rate of 66 2/3 percent. In the case of the Regional Rehabilitation Centres, the provincial government determines the amount of the allowance and reimburses the municipality for the total payment.

Each municipality sets its own policy on the maximum amount of comforts allowance to be paid to residents supported in Homes for Special Care. As well, each municipality determines the maximum accumulation a resident it is supporting may have in a comforts allowance account. In order to obtain provincial cost-sharing of comforts allowance, each individual municipality must submit its policy on comforts allowance to the Minister of Social Services for approval.

A review of forty-nine municipal policies revealed that the comforts allowance paid by the municipalities ranges from $30 to $75 per month. As well, seven municipal units have no written policy on comforts allowance, ten set their policy on an individual basis or follow provincial policy, and one has indicated that the family pays or a Court Order is sought.

COMFORTS ALLOWANCE

The Department of Social Services establishes the amount of comforts allowance paid to residents in the three Regional Rehabilitation Centres. Since 1976, the comforts allowance payment has been $30 a month for publicly supported residents who do not have the maximum accumulation of $100.

The Working Group on Comforts Allowance conducted a review of the actual comforts allowance payments for the month of May, 1983. The review revealed that 20 percent of the publicly supported residents in Homes for Special Care received no comforts allowance in the month of May, 1983. The review also revealed that many residents did not receive the maximum amount according to their respective municipal unit's policy.

There are a number of reasons why these differences existed, among which the most significant are:

- the family of the resident has agreed to accept financial responsibility for comforts
- the resident has reached the maximum comforts accumulation level as defined in their municipality's policy
- the functional levels of residents are different and some may be unable to utilize their comforts allowance at all or in part, thus the amount of comforts allowance received varies from one individual to another.

In addition to the comforts allowance paid by municipalities, 319 of the 356 residents in Regional Rehabilitation Centres received $30.00 per month comforts allowance in accordance with provincial policy. The remaining residents had reached the maximum allowable accumulation of $100 so did not receive comforts allowance in May 1984.

The Working Group also tried to determine the adequacy of the comforts allowance; however, their survey was inconclusive. Low allowances were often deemed adequate for persons receiving them while higher allowances were

considered inadequate in many cases. It would appear that the adequacy of the allowance depends upon the circumstances of the individual. Those who are mobile or who smoke would appear to need more money.

OTHER PROVINCES

The Working Group polled other provinces to determine if they had a comforts allowance program, and, if not, what method was used to leave or provide an individual with an allowance for his or her personal use. The provinces fall into two categories:

- the Atlantic Provinces which require individuals to contribute all their income to the cost of their maintenance in a Home for Special Care when public support is required and then provide a comforts allowance to the individual
- those provinces with a co-payment system where all individuals pay a fixed amount toward their care and the remaining income is left for the resident to use as he or she wishes.

Newfoundland, Prince Edward Island and New Brunswick provide a comforts allowance of $65, $50 and $70 respectively with no maximum accumulation.

In the other provinces with a standard resident co-payment, comforts allowance as such does not exist. The standard resident co-payment ranged from a low of $8 to a high of $15.19 per day. This would leave a resident with OAS/GIS income or the equivalent anywhere from $96 a month to $250 a month depending on the provincially required co-payment.

CONCERNS

Two concerns were expressed repeatedly to the Task Group:

- The disparity in comforts allowance from one municipal unit to another. Individual residents in the same Home, who are sometimes room mates, but are from different municipal units may receive different amounts for comforts, although their needs are basicially the same. This causes confusion for the residents, who cannot understand why one person receives more or less than another person. For the staff of the Homes the problem is one of coping with a resident who is disgruntled, or receives less comforts allowance than is needed by the individual.

- The inadequacy of the comforts allowance provided by most municipalities for residents in community settings such as group homes, where funds are required to participate in community activities.
  The primary objectives of community settings for the mentally handicapped and physically disabled are to provide opportunities for full participation in normal community activities and movement toward more or totally independent living situations. It was stressed by advocates for these residents that the amount of comforts allowance presently provided by most municipalities restricts this type of integration. Residents often neither have sufficient funds to participate, nor do they accumulate sufficient savings to equip apartments. The latter point was made specifically in relation to the physically disabled.

RECOMMENDATIONS

Both the Task Group and the Working Group are of the opinion that issues raised in relation to comforts allowance can only be resolved in the short term by

municipalities examining their policies, and attempting realistically to meet the needs of individual clients. In relation to the future, resolution of the difficulties will only come as part of a newly developed system for providing financial support to residents of Homes requiring public financial support.

The recommendations which follow are for the immediate future and are excerpted from the report on Comforts Allowance.

6.1 The municipal unit of settlement be required to pay each resident of a Home for Special Care the maximum monthly comforts allowance permissible in their policy up to the maximum that can be accumulated in the comforts allowance account.

6.2 The province require each municipal unit to submit a written policy on monthly comforts allowance and the maximum comforts allowance account accumulation.

6.3 The Department of Social Services give serious consideration to adjusting the monthly comforts allowance to $50 in Regional Rehabilitation Centres.

6.4 Special Social Assistance not be included in calculating the maximum that can be accumulated in the comforts allowance account.

6.5 Municipalities be encouraged to increase comforts allowance in light of increased needs of residents of Homes for Special Care.

In addition to the above recommendations the Working Group on Financing has made a recommendation regarding the treatment of comforts allowance and assets. This recommendation appears in Part 7 of this report but is noted here as well.

> **Municipalities should be encouraged and requested to estabish by 1987 uniform guidelines for the treatment of assets in determining need and uniform guidelines for the administration of comforts allowance for residents of Homes for Special Care.**

This recommendation suggests that uniform guidelines be established as an interim measure pending evaluation of a change in the method of providing financial assistance to residents in the long term.

Two recommendations were made in reference to the future; one by the Working Group on Comforts Allowance and one by the Working Group on Financing.

The Working Group on Comforts Allowance recommended an examination of comforts within the context of an overall review of funding. The Task Group supports this recommendation which is as follows:

> 6.6 **That the province be requested to re-examine comforts allowance within the broader context of the funding to municipal units for Homes for Special Care.**

In the section of this report on Financing, a recommendation on the future funding arrangements has been made. It is repeated here for ease of reference:

> **A joint provincial-municipal study group should be formed to review and assess the feasibility of establishing a regional approach to the development, administration and funding of programs related to Homes for Special Care and related community services.**

PART 7

FINANCING

7.0 FINANCING

The Working Group on Financing was co-chaired by two members of the Task Group and included the remaining members of the group, two additional members of the Department's senior staff, and representatives from the Nova Scotia Union of Municipalities and the Associated Homes for Special Care. Because of the composition of the Working Group the Report on Financing represents the views of the Task Group. Therefore, the "Conclusion and Recommendations" section has been included here in total, with only minor editorial changes.

The other two main sections of the Report on Financing provided an overview of the current funding structure for Homes and an interprovincial comparison of costs. Much of the contents of these sections have been consolidated in the conclusions and recommendations, and have not therefore been summarized by the Task Group for inclusion in this report.

In the Province of Nova Scotia, municipalities are responsible in law for the placement and maintenance of needy persons in Homes for Special Care, while the Province is responsible for licensing and the monitoring of standards of care in Homes. The Province cost shares with municipalities in their approved maintenance expenditures at the rate of 66 2/3 percent for all Homes except Regional Rehabilitation Centres, which are shared at 100 percent.

The above arrangement is unique in Canada. In the Atlantic Provinces, individuals have primary responsibility for their own maintenance in Homes. However in all provinces except Nova Scotia, the provincial government is responsible for the maintenance of persons in need. The remaining Provinces have an insured co-payment system, with the provincial government primarily responsible for the funding of residents over and above a standard resident co-payment.

The issues relating to funding of Homes are examined under the following subject areas.

- Funding of Homes and Residents
- Provincial-Municipal Financial Relationships
- Per Diem Rates
- Regionalization

The study carried out by the Task Group was based on two assumptions:

- the Department of Social Services, through the Homes for Special Care Act and Regulations, will continue to require owners and administrators to ensure that residents in Nursing Homes, Homes for the Aged and Residential Care Facilities, regardless of their auspices, receive quality care

- government will maintain but not substantially increase its level of support to municipalities, who are and will continue to be required by law to maintain persons in need in such Homes.

In light of these assumptions, the Working Group first looked at how residents of Homes are funded.

7.1 FUNDING OF HOMES AND RESIDENTS

In examining the most appropriate method of funding Homes for Special Care, the committee looked at four options: an insured co-pay system similar to Ontario and the Western provinces; a cost to income option; an option to insure the nursing component of care; and the needs test approach which is currently in place in Nova Scotia and the other Atlantic Provinces.

INSURED SERVICE WITH CO-PAY

Insured service with co-pay is a system whereby the resident of a home is responsible for a fixed daily or monthly payment, usually geared to OAS/GIS levels of income. Persons with insufficient income to pay the fixed amount can apply to the local social service department for assistance. Government then pays the home the difference between the per diem rate and the co-payment. This is the system in place in the majority of provinces in Canada. If Nova Scotia were to adopt such a system, the following is a breakdown of the estimated cost.

In 1984-85 the total operating budgets of all Homes for Special Care in Nova Scotia is estimated to be $120.5 million. It is anticipated that municipalities will pay $67.5 million with $49.1 million provincial sharing, for the maintenance of 75 percent of the 7675 residents in all Homes. Therefore, approximately $53 million will be paid by the residents directly, including the 1900 residents (25 percent of the total) who are totally private paying.

In considering an insured service, we have excluded Residential Care Facilities as no province insures that level of care. The remaining Homes, including Homes for the Aged, Nursing Homes, Adult Residential Centres, Group Homes and Regional Rehabilitation Centres, will cost approximately $113.8 million to operate in 1984-85. In total these facilities provide service to 6643 residents. The total municipal payment to these Homes will amount to $65.3 million with $47.6 million provincial cost-sharing under the present cost-sharing arrangements.

If, under an insured system with co-pay, we assume a monthly co-payment of $476 ($15.65 per day) based on the OAS/GIS maximum less sixty dollars per month comforts allowance, the co-payment should produce approximately $37.9 million annually. (6643 residents x $15.65 per day x 365 days.) The $37.9 million from the co-payment and the $65.3 million municipal cost would produce a total revenue of

$103.2 million against a total cost of $113.8 leaving an amount of $10.6 million to be funded under the insured system.

However, it is estimated that approximately 1700 residents would be unable to afford the full co-payment and would require government assistance to provide the $15.65 per day residents contribution. These 1700 residents would require approximately $5.7 million to supplement the co-payment and thus the total additional cost of a co-pay system to the provincial or municipal levels of government would be $5.7 million + $10.6 million, or a total of $16.3 million additional public dollars.

Advantages

- This simplification of the present needs test would reduce administrative costs.

- Residents would not have to deplete life savings before being eligible for assistance.

- There would be no necessity to pay comforts allowance except to a few senior citizens.

Disadvantages

- There would be substantial increase in government costs

COST TO INCOME

Under this option, persons in Homes for Special Care would pay a percentage of their income (e.g. 90 percent) towards the cost of their care. Where 90 percent of

a resident's income exceeds the per diem rate, the individual would pay the full per diem rate.

This approach represents a major change in the philosophy in the financing of Homes for Special Care. At present, before any public financing is available for an individual in a home, he or she must be found to be in need. In determining need, all income is applied to the cost of care. Comforts Allowance is granted as an item of assistance.

Under the cost to income option, the program in effect would become a subsidized service. The price would vary according to a person's income and the cost to the individual would be ninety percent of his or her income. To maintain consistency in this approach, assets should be ignored. However, this is not absolutely necessary.

From the perspective of the individual, this option has many advantages. Individuals who have saved during their lifetime but whose savings are not adequate to cover costs, are not dependent on public assistance. Those who have saved more will be able to keep more and benefit from their thrift. This seems to be in keeping with commonly held beliefs about equity. Also, persons with the same income will be paying the same price for the same service - another condition of equity.

This option presents several problems, particularly as it relates to disabled persons. The current OAS/GIS maximum for single persons is $533 per month. This would give a senior citizen a minimum comforts allowance of fifty-three dollars per month. The Family Benefits board-rate received by many disabled persons is $307 per month which would give a comforts allowance of $31 per month. It has been suggested that disabled persons, particularly those living in group homes, need a higher comforts allowance than most seniors. The proposal would not satisfy this need. To deal with this situation, it might be possible to introduce a minimum amount to be retained by the resident equal to ten percent of maximum OAS/GIS.

This approach may also present problems with cost-sharing. The needs test is a basic requirement for cost-sharing and as a condition, income from most sources must be charged at 100 percent. Federal cost-sharing for residents in Homes for Special Care is approximately $3.5 million annually. In order to implement the proposal, it would probably be necessary to forgo this cost-sharing.

The proposal also represents a change in the relationship between the Province and the municipalities. In the past, municipalities have been allowed to set their own comforts allowance, subject to a provincial maximum.

The September 1983 data from the municipal claims for Homes for Special Care was compiled by the Working Group on Financing and used for the cost estimates. These data are only available in an aggregate form so it is not possible to determine the impact on individual residents and municipalities.

Annual Increase = $1.42 million (ten percent of income less present comforts allowance)
Plus possible loss of cost-sharing $3.5 million
Total additional cost $4.92 million

Advantages

- Individuals who have saved during their lifetime but whose savings are not adequate to cover costs, are not reduced to dependence on public assistance.

- There will be no necessity to pay a comforts allowance except to a few Senior Citizens. The minimum amount a senior citizen will retain is currently $53 per month.

- This option is not as costly as the universal co-pay option.

Disadvantages

- Federal cost-sharing of approximately $3.5 million per year is likely to be lost.

- Additional costs would be distributed unevenly among the municipalities. The cost burden for each one would depend upon the financial situation of their residents in homes, the per diem rate in the Home and the current comforts allowance.

INSURED NURSING COMPONENT

This approach is based on the principle that the resident should be responsible for the normal living costs of a Home such as food and shelter, while the care component unique to the Home would be insured. This option was not examined in detail due to the lack of accurate information available on the breakdown of the various costs involved, and the wide range of per diem rates across the province. However, preliminary calculations indicate that this option is the most expensive to government and in the current fiscal circumstances this option was not pursued further.

NEEDS TEST

In Nova Scotia residents of Homes for Special Care are responsible for their own maintenance costs in Homes. If a resident is not able to pay the total maintenance costs, he may apply to the municipality of settlement for assistance with maintenance costs in whole or in part. As of May 1, 1984, there were 7675 persons in Homes for Special Care in Nova Scotia. One thousand nine hundred of these persons, or 25 percent are private paying. The remaining 5762 or 75 percent receive maintenance assistance, in whole or in part, from their municipality of

settlement. In the year ending March 31, 1984, municipalities paid a total of $64.3 million for the maintenance of persons in Homes for Special Care. Of this amount, the Province reimbursed the municipalities $46.8 million.

In determining whether a person qualifies for maintenance assistance in a Home for Special Care, the municipality looks at three main areas of personal finances - monthly income, liquid assets and fixed assets. The treatment of monthly income and liquid assets is relatively uniform throughout the province. Monthly income is applied directly to maintenance costs. In terms of liquid assets, provincial guidelines provide that a resident may have $3,000 if single, and $5,500 if married, and still be eligible for maintenance assistance. However, most municipalities establish their own liquid asset limit below the provincial amounts and in fact the usual asset limit allowed by municipalities is $1000 if single, and $1500 if married.

In terms of fixed assets such as property and buildings, there is some divergence as to how these assets are treated in determining need. Some municipalities pursue the area of fixed assets in a vigorous manner while others do not pursue it at all. The majority of municipalities adopt a policy of analyzing each individual situation, consequently the disposition of fixed assets is determined individually. Nevertheless, the application of the needs test in Nova Scotia has resulted in the lowest government per-resident cost of any province in Canada.

The major argument against the needs test is that persons who have been frugal and acquired some assets during their life-time are required to deplete their assets almost entirely before receiving government assistance. Others who may have freely spent their assets or who have been able to plan for the disposal of their assets in advance can receive government assistance immediately. The following outlines the pros and cons of the needs test system.

Advantages

- Those persons able to pay for care are required to do so.

- Municipal and Provincial expenditures are held to a lower limit due to private contributions.

Disadvantages

- Private paying residents are required to deplete their savings almost entirely before being eligible for maintenance assistance.

- Some residents who have assets are able to dispose of those assets by means of pre-planning and legal advice and become eligible for maintenance assistance sooner than would otherwise be the case.

- Not all municipalities throughout the province treat fixed assets in the same manner, thereby creating inequities based on place of residence.

In addition to the financial considerations, the question of an insured service versus a needs test approach is one which evokes a good deal of subjective reaction. On one hand, it can be argued that residents of Homes for Special Care should be responsible for their own maintenance costs as long as they have sufficient funds. On the other hand, it can be argued that persons with modest lifetime savings are required to deplete practically their entire savings in a Home for Special Care and become needy persons before being eligible for maintenance assistance.

Nova Scotia, with its joint provincial-municipal funding system of Homes for Special Care, has the lowest per capita cost in Canada for maintaining persons in Homes. Also the general standards of care are considered to be equal to or better than the general standard of care across the country. After consideration of the foregoing options, and having regard to the financial implications of each, there does not seem to be any alternative but to continue the present method of funding homes and residents since this would not result in increased costs to the Province or municipalities. It is therefore recommended that:

7.1.1 The maintenance of persons in homes for special care should remain primarily an individual responsibility, with municipal support available for persons in need on the basis of a needs test.

It is recognized that a major inequity in the present system is that all municipalities do not treat fixed assets in a similar manner. There is little consistency in municipal policies and the way those policies are applied. In fact, a minority of municipalities have no stated policy on the treatment of assets. It can be argued that the varying standards applied reflect local community standards, and are consistent with the administration of municipal assistance programs. On the other hand, it can be argued that all residents should be treated consistently in determining their need for maintenance assistance.

Another area in which there is much inconsistency is that of comforts allowance, as is evident in the report of the Working Group on Comforts Allowance.

The Working Group on Financing felt that municipalities should be encouraged to develop uniform guidelines for the treatment of assets, income and comforts allowance which would be flexible enough to accommodate individual circumstances but, at the same time, provide a measure of equity and consistency now lacking. It was also felt that this task should be accomplished within a specific time period, perhaps two years. It is therefore recommended that:

7.1.2 Municipalities should be encouraged and requested to establish by 1987 uniform guidelines for the treatment of assets in determining need, and uniform guidelines for the administration of comforts allowance for residents of Homes for Special Care.

The current system of individual responsibility for maintenance in a home, with municipal support for persons in need, provides a quality of care at a reasonable cost to government relative to other provinces of Canada. On the other hand, the costs to the individual are greater under a needs test system than the insured co-pay type of system which is in operation in the majority of provinces. Both the cost to income approach and the insured co-pay approach lessen the cost to the individual, although both are more costly to government than the needs test approach.

While the current economic situation may not allow there to be substantial increases in expenditures in this area, future developments might permit the development of a different approach to funding in Nova Scotia. Consequently, the Working Group was of the view that, while the needs test approach should be maintained in the immediate future, the longer term goal should be to develop a system of funding homes whereby residents would not have to be reduced to a position of need before maintenance assistance is available. It is therefore recommended that:

7.1.3 A method of funding residents in homes should be developed which would permit residents to retain a larger portion of their financial resources than is now the case, while ensuring that they continue to make some contribution toward their maintenance costs. This approach could take the form of a cost to income or insured co-payment system.

7.2 PROVINCIAL - MUNICIPAL FINANCIAL RELATIONSHIPS

Municipalities are responsible under law for maintaining persons in need in Homes for Special Care, and the Province shares approved costs with municipalities at the

rate of 66 2/3 percent. In 1984-85 it is estimated that municipalities will spend $67.5 million on the maintenance of needy persons in Homes with $49.1 million provincial cost-sharing at the rate of 100 percent for Regional Rehabilitation Centres and 66 2/3 percent for all other Homes.

The Working Group looked at two basic approaches determining the provincial contribution to the municipal expenditures on Homes for Special Care, cost-sharing and block funding. Two variations of cost sharing were reviewed. The first was the existing relationships in which municipalities retain responsibility for placing and maintaining needy residents in Homes for Special Care with provincial cost sharing at a fixed percentage on all approved expenditures. The following table indicates Provincial and Municipal expenditures on Homes over the past six years, based on 66 2/3% cost-sharing for all Homes except Regional Rehabilitation Centres which are shared 100% by the Province.

PROVINCIAL/MUNICIPAL EXPENDITURES
HOMES FOR SPECIAL CARE
(IN MILLIONS OF DOLLARS)

	Total Municipal Expenditure	Provincial Share	Net Municipal Share
1978-79	$ 34.4	$ 25.3	$ 9.1
1979-80	$ 39.5	$ 28.8	$10.7
1980-81	$ 45.1	$ 32.9	$12.2
1981-82	$ 53.1	$ 38.9	$14.2
1982-83	$ 60.4	$ 44.1	$16.3
1983-84	$ 64.3	$ 46.8	$17.5

The major problem with the current system relates to the process by which cost-sharing is effected. Typically, the Province approves cost-sharing on a specific budgeted amount for each municipality at the beginning of each fiscal year. This approval may be based on a level of expenditure not related to anticipated costs. Subsequently, at a later date in the fiscal year approvals are reviewed and have been adjusted to meet actual approved expenditures.

The result of this process is that the municipalities cannot accurately predict their net costs in any given year until the fiscal year is well advanced or possibly completed and the Province cannot predict its net costs until midway through its fiscal year.

Cost-sharing by its very nature implies sharing of all approved costs. To a large extent approved costs can be predicted by examining the major factors which affect municipal expenditures including:

- New beds
- Income level of residents
- Increases in the number of publicly supported residents
- Per diem rates

An examination in detail of these four factors at the beginning of the fiscal year should provide a reasonably accurate estimate of expenditures for any given year considering past years expenditures. The approval of new beds is controlled by the Province and per diem rates are largely controlled by the rate setting process. The other two factors can be reasonably predicted based on past experience.

The major problem areas of the present cost-sharing method seem to relate more to the procedure followed than to the principle of cost-sharing itself. While the overall cost can be predicted with reasonable accuracy, it is very difficult to predict the cost of any given municipality particularly the smaller municipalities.

For this reason, final cost-sharing approvals often cannot be established until well into the fiscal year.

A major concern with open ended cost-sharing is that demands may be greater than the funds available to the Province. A reasonably accurate prediction of total expenditures would mean that the Province could predict its costs based on any given cost-sharing percentage. Municipal net cost would be affected by the Provincial cost-sharing rate but would be reasonably predictable for any given percentage of cost-sharing. Based on expenditures for the year ending March 31, 1984 each percentage point of Provincial cost-sharing amounted to $528,000.

Advantages

- provides cost-sharing on all approved expenditures on behalf of persons in need.

Disadvantages

- difficult to predict actual cost to individual municipalities.
- final cost-sharing approvals often delayed until late in the fiscal year.

The second variation was to have municipalities retain responsibility for placing and maintaining needy residents in Homes for Special Care, with provincial cost sharing at a fixed percentage on a fixed amount of municipal expenditure.

This variation implies cost-sharing at a fixed rate on expenditures up to a maximum level. For example, it might involve cost-sharing at 66 2/3 percent on an amount of not more than 105 percent of the previous years expenditure.

In fact this approach amounts to a type of block funding and the issues relating to it are examined in more detail in the next section. This approach may not be sensitive to the needs of a particular municipality where, for example, one

additional client may increase the caseload and cost by a substantial percentage. A municipality with four people in Homes would have a twenty-five percent increase in cost with one additional client requiring care in a Home.

While this approach sets a ceiling on the upper limit of Provincial cost, it does not necessarily ensure Provincial participation in the provision of service to all persons in need throughout the province.

This option does permit both the Province and Municipalities to predict with reasonable accuracy their net costs in any given fiscal year. It does not, however, ensure that cost-sharing is available where it may be most needed.

Advantages

- administratively simple in terms of determining cost sharing approvals
- both provincial and municipal net costs can be determined with reasonable accuracy.

Disadvantages

- may not be equitable to all municipal units
- may not provide cost sharing where it is most needed.

BLOCK FUNDING

With block funding, the Province would make a grant based on a formula to each municipality and the municipality would then be responsible for the cost of maintaining persons in need in Homes for Special Care.

Attempts were made to develop a formula which would result in a standard expenditure for each municipality approximating current actual expenditures. This approach is similar to that used by the Federal Government for the Established

Program Financing program, in which funding is not directly related to program costs. The variables considered included:

- Population over age sixty-five
- Percentage of publicly supported residents
- Weighted average per diem rate
- Revenue from OAS/GIS

The expenditures determined for each municipality using the formula bore little relationship to actual expenditures. Modifications to the formula did not provide any better results, primarily for the following reasons:

- Variations in utilization rates from municipality to municipality.
- Variations in costs, e.g. salaries and capital costs.
- Variations in the percentage of publicly supported residents.
- The number of smaller municipalities where any change in the number of residents can produce large changes in expenditures.

There is a wide variance in the size of the population in municipalities throughout Nova Scotia. The largest municipality in terms of population is approximately 120 times the size of the smallest municipality. The ten largest municipalities contain 50 percent of the province's population while there are more than twenty municipalities with less than 5000 residents.

In a small municipality with for example three persons in Homes, the addition of one person can mean a 33 1/3 percent increase in costs. On the other hand, a municipality with 400 residents in Homes can place an additional twenty-five persons in Homes with a 6.2 percent increase in costs.

Coupled with the differences in population size, the ability to pay also differs between municipalities as determined by per capita assessment.

As a result, the cost of providing Social Services and in particular maintenance in Homes for Special Care can vary widely as a percentage of a municipality's total budget. In a large municipality with a large assessment base the Social Service component of the total municipal budget may be less than 10 percent, while in a small municipality the percentage may be 20 percent or more.

A block funding arrangement which would be administratively simple for 67 municipal units would inevitably lead to inequities. A block funding arrangement which would take into account all the variables in 67 municipal units would necessarily be administratively complex.

Block funding would also fundamentally change the relationship between the Province and the municipalities in terms of the provision of Social Services. In a block funding environment, the control of costs would rest almost entirely with the municipality. It is reasonable to assume that the Province would no longer be involved in the rate setting process or in determining bed requirements in the future, although the Province would in all likelihood retain the responsibility for licensing and standards of care.

Advantages

- Each municipality would have a fixed provincial revenue each year. This would facilitate planning.
- The Province would be better able to control provincial expenditures on the program.

Disadvantages

- The needs of some small municipalities, where a small change in the number of publicly supported residents can result in a substantial change in cost, are unlikely to be met.
- Provincial involvement in promoting and maintaining quality programs in homes would be lessened.

As previously noted, a major problem with the current cost sharing procedure is that the final cost sharing approvals are often delayed until late into the fiscal years of both the Department and the municipalities. This seems to be endemic to the process itself. It is doubtful whether this problem can be satisfactorily resolved when cost sharing approvals have to be set for 67 municipalities which are so varied in size.

Provincial cost sharing with municipalities in maintenance costs in homes has, however, been vital to the development of the Homes for Special Care system now in place in the province. In 1983-84 Provincial funding amounted to 73 percent of the total government funding of Homes.

In short, the present cost-sharing system, in spite of its procedural problems, has a distinct advantage over a block funding arrangement involving 67 municipal units. The cost sharing approach does apply funds directly to expenditures on behalf of persons in need in homes, which might not be the case with block funding. The block funding approach might on the other hand have a good deal to commend it if a regional system with municipal administration of Social Services programs were in place. This possible approach is addressed later in the report. In conclusion, the Working Group recommends that:

7.2.1 All approved expenditures by municipalities for the maintenance of persons in need in Homes for Special Care should be cost shared by the province.

REGIONAL REHABILITATION CENTRES

As noted earlier the Province shares with municipalities at the rate of 100 percent for Regional Rehabilitation Centres and at the rate of 66 2/3 percent for all other

Homes. This has distinct program implications. It is obviously to the advantage of municipalities to have persons remain in Regional Rehabilitation Centres despite the fact that an individual might be more appropriately placed in another type of facility or in the community.

The 100 percent provincial cost-sharing for residents of Regional Rehabilitation Centres is based on historical Provincial responsibility for municipal mental hospitals. Since these facilities have been integrated in the total system of Homes for Special Care, there is now an argument for reviewing the funding mechanism.

The Working Group on Services to Mentally Handicapped Adults recommended that a committee be established to review the present cost-sharing structure as it relates to specialized residential service to the mentally handicapped. This committee should report on the feasibility of:

- adapting cost-sharing with Regional Rehabilitation Centres to reflect the same percentage of contribution from a municipal unit as is the case with all other types of homes for special care. (It is suggested that this might be accomplished without any general impact on overall municipal or provincial levels of contributions, by increasing the provincial cost-sharing level from 66 2/3 percent to 73 percent for all clients in homes for special care)

- adjusting provincial cost-sharing in order to provide financial incentives to municipal units to use community- based placements wherever possible.

Any change in the cost sharing formula for Regional Rehabilitation Centres would not affect all municipalities equally as the number of residents in Regional Rehabilitation Centres from each municipality varys as a percentage of all residents in homes varys and would require careful analysis. The Working Group on Financing agreed that such a review should be carried out, and that the committee

formed should be representative of all parties affected including municipal representation.

7.3 RATE SETTING

In all other provinces the provincial government establishes the per diem rates at which it will purchase services provided by Homes. This practice reflects the nature of the market in which Homes operate - a virtually non-competitive market in which government controls the supply (the number of beds), demand is high, and immediate alternatives are not usually possible.

By practice, not law, Homes in Nova Scotia until recently billed municipalities at the rates established by the Department of Social Services. In 1982 and 1983 the Department of Social Services established rates arbitrarily in that all per diem rates were subjected to a maximum percentage increase regardless of the assessment of need procedure. Under this practice some Homes commenced billing municipalities at rates in excess of those established by the Department for cost-sharing purposes.

The majority of the presentations from municipalities to the Task Group recommended municipal involvement in the rate setting process, particularly to alleviate the situation which occurred in 1982 and 1983 where they were billed over the cost-shareable per diem rate, and had no knowledge or mechanism to determine if the rates were appropriate.

The Working Group concluded that municipalities should be involved in establishing guidelines each year for the Departmental Rate Setting Committee. A central body is necessary for administrative purposes and, therefore municipalities should become involved through the Union of Nova Scotia Municipalities.

It is therefore recommended that:

7.3.1 An advisory committee to the Department of Social Services including membership from the Department of Social Services and the Union of Nova Scotia Municipalities should be established to recommend guidelines annually for the establishment of per diem rates. Homes for Special Care should be encouraged to make collective representation to the advisory committee.

7.3.2 Approved per diem rates should be established for Homes for Special Care by the Department of Social Services Rate Setting Committee.

7.3.3 Per diem rates for Homes should be established based on an assessment of need and should reflect actual operating costs and established departmental guidelines.

7.3.4 Additional charges made to private paying residents should be nondiscriminatory in that additional charges should be related to additional services provided to the resident.

Accounting policies related to capital for the non-profit sector are largely dictated by policies established by the Department of Municipal Affairs, the Nova Scotia Department of Housing, and Canada Mortgage and Housing and are employed in rate setting.

The Departmental guideline related to capital in the private profit sector is effectively a cost plus system. This system provides for a ten percent profit

allowance, and depreciation at one half the rates established by Revenue Canada for income tax purposes on all approved expenditures.

There are no established policies regarding:

- minimum owner's equity
- minimum/maximum mortgage term
- maximum interest rates
- additional capital costs resulting from the purchase or sale of a Home.

The committee therefore investigated a number of options for establishing per diem rates for the private profit sector.

Objectives of the Committee were:

- to ensure the maintainance of the private sector in the industry.
- to ensure that per diem rates are both competitive and adequate to provide care comparable to that provided by the non-profit sector.
- to establish a system whereby expectations of the purchasers (government) are funded and indicated to the operators.

An owner's capital costs consist of mortgage payments and return on investment. The capital component of a per diem rate only accounts for approximately 15 percent of the rate. It is, however, the single most difficult area to address in terms of establishing guidelines.

There are four basic approaches used to reimburse capital costs:

1. Historical Costs

   Historical Cost is the cost of constructing a Home when it was first built or renovated. This approach results in the least cost to the

purchaser but does not recognize appreciation in the value of the property.

2. Replacement Costs

This is an estimate of the cost of rebuilding the Home. This approach may result in costs that are too high in that they are in excess of what is required to keep the Home in operation and are in excess of the non-profit sector who have the advantage of low interest rates.

In Nova Scotia 28 percent of the Level I and II care beds are operated by the private profit sector. There is therefore an element of competition with the non- profit sector. Per diem rates must be competitive to ensure a place in the market in the long run.

3. Market Value

This is the price a Home will bring on the private market. Market value is highly influenced by current and potential income, and by appreciation of property. It is also highly influenced by government policies regarding capital.

4. Imputed Value

This is a value established independent of actual cost experience. An advantage of this approach is that it is not necessary to monitor financial behavior of a Home related to capital or to respond to transactions such as the sale of a Home or refinancing. The primary problem with this approach is developing a methodology for deriving the imputed value that is equitable.

In other provinces a standard per diem rate is usually established for all private profit Homes with no policies related to capital.

Disadvantages

- It creates a wide variance between Homes in the quality of care provided
- It tends to minimize expenditures related to providing care
- Government has little leverage to promote acceptable standards of care.

The Working Group concluded that individual rates should be established for each Home, that the operating component should be established in the same manner as the non-profit Homes, and that the capital component in each Home should be fixed and based on the imputed value approach.

Advantages

- It encourages a favorable debt to equity conversion thereby allowing the operator to increase profit by paying down debt

- It minimizes administration related to the capital component

- It removes government involvement when a change of ownership or other related capital transactions such as remortgaging (is comtemplated)

- It separates care/operating from the profit factor

- It provides leverage to enhance or develop program standards

- Government can maintain a central repository of information regarding operating costs for planning and control purposes.

The methodology recommended to determine the imputed capital component for each Home is to use 1981 as a base year in determining historical capital cost plus the cost of financing, plus a profit factor. This approach allows the cost saving advantage of the historical cost approach, weighted favorably to the Home by the 1981 profit factor. In terms of monitoring, Homes should be permitted up to a two percent favorable variance on the approved operating budget where they are able to effect cost savings.

It is therefore recommended that:

7.3.5 A split rate system with an operating and capital component should be established for each private profit home. The operating component should be established in the same manner as for non-profit homes, i.e. through detailed assessment and approvals.

A fixed capital component should be established for each private profit home. Using 1981 as a base year a fixed capital component rate would be established for each home based on historical capital costs plus the cost of financing plus a profit factor. In subsequent years the operating rate would be set annually while the capital component would remain unchanged.

The Working Group reviewed the role of the private profit and non-profit sectors in the delivery of services. A review of the ownership of Homes in other provinces has indicated that government costs tend to be less in provinces where a high proportion of beds are operated by the private sector.

The Committee concluded that there should be a process in place whereby each type of ownership - private non profit, public and private profit -is given the opportunity to compete when it is determined that there is a need for new beds.

7.3.6 A procedure should be developed to provide opportunity for the public, private profit and non-profit sectors to make proposals for the development of new homes when a need is determined. Such proposals would be reviewed by a joint committee of the Province and appropriate municipalities.

The one rate versus two rate system of per diem rates was specifically identified for review in the Terms of Reference for the Task Group. Ten years ago the Department of Social Services developed a formula which allocated the costs associated with heavy care residents at a ratio of 11/9ths of the costs associated with light care residents.

Approximately one-half of the Homes for the Aged and Nursing Homes have a two rate system, i.e. a per diem rate for light care (Level I) and a per diem rate for heavy care (Level II). The remainder have one rate for all residents. The two rate system is advantageous to light care residents, who pay privately, while the one rate system provides ease of administration.

For the past two fiscal years, the Department has applied annual maximum percentage increases to the previous year's approved average rate for Homes with a two rate system. This in effect voids the purpose of a two rate system when a

Home changes its ratio of light to heavy care residents during the year. Given that the mix of heavy and light care residents in a Home is permitted to fluctuate to meet demands and that the additional costs, (associated with caring for heavy care residents), as alloted by the formula, is reasonable; then it could be argued strongly that the option of the two rate system should remain with the home.

It is therefore recommended that:

7.3.7 The option of a one rate or two rate system should remain with the home.

Two common concerns expressed by municipalities who made presentations to the Task Group were the budget problems caused by per diems not being established on the same date each year, and adjustments being made several times during the year. A number of Home operators expressed concern with the length of time between the beginning of their fiscal year and notification of the approved per diem rate.

Under the present rate setting procedures, four or five months may lapse after commencement of the per diem rate year before a Home is notified of the approved per diem rate. This situation only serves to make the approved per diem rate less meaningful to operators of Homes.

To facilitate municipal/provincial budgeting and provide operators with more timely information, the following recommendations are made:

7.3.8 Per diem rates for all Homes for the Aged, Nursing Homes, Group Homes, Regional Rehabilitation Centres and Adult Residential Centres should be established effective January 1 of each year. Per diem rates for all private profit Residential Care Facilities should be established effective July 1 of each

year. The fiscal year of a Home should coincide with the per diem rate year.

7.3.9 Homes should be required to make budget submissions to the Department of Social Services three months prior to the beginning of the per diem rate year.

7.3.10 Final approval of a per diem rate should be communicated to each Home no later than one month after commencement of the per diem rate year in a standard budget format. A request for a revision of the approved per diem rate should be within 60 days of notification.

Comparison between similar size and types of Homes is a valuable tool in assessing the reasonableness of costs. In order for meaningful comparisons, it is necessary that budget allocations and reporting be standardized for all Homes in each program with items well defined in each budget subject.

Collection of data for information and planning purposes would be greatly helped by standardization. It is therefore recommended that:

7.3.11 A standard budget submission format should be developed for each type of Home for Special Care, including a standard staffing format, to indicate actual staffing pattern. Budget submissions should be approved and signed by the appropriate authorities, which should include two members of the board of directors in the case of non-profit homes.

7.3.12 Financial Statements of Homes should follow a similar format to the budget submission format.

Regardless of the manner in which per diem rates are established, it is not possible to guarantee that a Home will not incur a deficit. The reasons for a deficit can be many and varied ranging from lack of management control to the unforeseen replacement of a boiler. In the past it has been common to fund deficits through retroactively adjusting a previous year's per diem rate. A prior period adjustment has caused problems for municipalities since their books are usually closed before the adjustment is made. Ongoing quarterly monitoring of a Home's budget plus tighter applications of the recommended procedures for establishing per diem rates should reduce the incidents of deficits.

It is therefore recommended that:

7.3.13 Deficits incurred in non-profit Homes should be considered in the process of setting the rates for the next fiscal period. The practice of setting retroactive rates should be discontinued. If the deficit is deemed to have been incurred due to circumstances beyond the reasonable control of the Home, and the request for a revised rate is accompanied by a detailed action plan for correction acceptable to the committee, then the need to raise revenues to liquidate the deficit should be recognized.

7.3.14 All non-profit Homes should submit quarterly financial statements to the Department of Social Services in a form prescribed by the department. All private profit Homes should submit annual financial statements.

7.3.15 A Financial and Management Audit Program should be developed by the Department of Social Services for all Homes for Special Care.

The Working Group felt that educational programs in financial management and staffing would be most beneficial in promoting sound management of Homes. There are a number of organizations such as the Nova Scotia Association of Health Organizations, Associated Homes for Special Care and the Institute of Public Affairs of Dalhousie University who may now have appropriate programs developed or may be interested in working with the Department of Social Services in developing such programs.

7.3.16 Educational programs should be developed for Homes in the areas of finance and staffing management.

In summary the Working Group concluded that a centralized rate setting process can:

- best align Homes' costs with accepted standards of care having regard to government budgets
- facilitate the budget process for Homes and government
- promote sound financial management and control through increased communication, information sharing and consultation.

Most of the changes referred to above will be effected through the rate setting process, and will require the acquisition of additional staff for the development and monitoring of new systems and procedures.

7.4 REGIONALIZATION

As mentioned earlier, the wide variation in municipal population throughout the province and the differing financial capacity of municipalities makes it very difficult to predict accurate costs on an individual municipal basis. Furthermore, the availability of programs such as homemaker services, which might have an impact on Homes for Special Care costs, varies from one municipality to another.

A regional approach to the administration, development and funding of services related to Homes for Special Care could permit the development of a wide variety of alternative approaches relating to the funding of Homes, provincial-municipal financial relationships, bed needs, classifications and assessments and the establishment of per diem rates. Such an approach could also facilitate recognition of municipal ability to pay, to which the present system cannot readily adapt. For example, provincial block funding based on regional need would be much more feasible than under the present arrangement.

In addition, the administration of all non-profit homes within a region might be co-ordinated in terms of financial management, personnel policies and possibly purchasing procedures. In the area of planning for services to the mentally handicapped, the availability of resources could be enhanced and the development of related programs (such as homemaker services) could be more closely co-ordinated with existing residential facilities.

Finally, the budgeting process would be facilitated by creating a larger base for planning purposes. An increase of one or two residents in a smaller unit might be offset by a similar decrease in a larger unit which would provide a more flexible response to meeting need where it exists.

The establishment of a regional approach would require extensive further study to explore all the ramifications. It is therefore recommended that:

7.4.1 A Joint Provincial Municipal Study Group be formed to review and assess the feasibility of establishing a regional approach to the development, administration and funding of programs related to Homes for Special Care and related Community Services.

PART 8

GENERAL ISSUES AND CONCERNS

8.0 GENERAL ISSUES AND CONCERNS

8.1 PROVINCIAL-MUNICIPAL RELATIONSHIPS

The present Homes for Special Care system in Nova Scotia has been a joint development of the provincial and municipal levels of government. Municipalities are responsible under the provisions of the Social Assistance Act for the placement and maintenance of needy persons in Homes for Special Care. The Province is responsible for the licensing of Homes and the maintenance of standards of care. In addition, the Province cost shares with municipalities at the rate of 66 2/3 percent of the approved costs of maintaining needy persons in all Homes, except Regional Rehabilitation Centres which are cost shared at 100 percent.

In the fiscal year ended March 31, 1984, municipalities paid a total of $64.3 million for the maintenance of persons in Homes and the Provincial cost sharing amounted to $46.8 million with a net municipal cost of $17.5 million. Of the total public dollars spent on the maintenance of needy persons in Homes, the Province contributes 72.7 percent and the municipalities 27.3 percent. Any decrease in Provincial financial support to municipalities for Homes would mean a major increase in municipal costs. For example, a 10 percent decrease in the provincial contribution would mean a 26.7 percent increase in municipal costs.

The Province also gives final approval for the development of new homes. Since 1965, thirty-two new Homes for the Aged and Adult Residential Centres have been constructed, and five Homes for the Aged and Adult Residential Centres have undergone major renovations with provincial approval.

Municipalities which met with the Task Group strongly believed that a continuing provincial involvement in the funding and administration of Homes for Special Care was vital to maintenance of the high standards of care now available in Homes in Nova Scotia. Most municipalities see licensing, classification and rate setting as functions requiring specialized knowledge which is only available at the provincial level. At the same time, municipalities have indicated a desire to maintain their

current involvement, as required by law, in maintaining and funding needy persons in Homes. Only one or two municipalities which met with the Task Group objected to the municipal financial contribution of 33 1/3 percent. For the majority of municipalities the major concern was the uncertainty surrounding provincial cost-sharing.

The present system of joint provincial-municipal responsibility for Homes in Nova Scotia has produced low government costs, while in the opinion of the Task Group providing a high quality of care compared to that provided in other Homes for Special Care throughout the country. Only Prince Edward Island has lower absolute costs for Homes for the Aged and Nursing Homes. At the same time, the present system maintains local community involvement in both the financing and administration of Homes for Special Care. This seems to be consistent with the total Municipal Social Services program which provides for a reflection of local community standards.

The Task Group therefore recommends the continued joint provincial municipal responsibility for maintaining persons in need in Homes for Special Care and supports the recommendation of the Working Group on Financing that:

8.1.1 All approved expenditures by municipalities for the maintenance of persons in need in Homes for Special Care should be cost shared by the Province.

8.2 AUSPICES - SOCIAL SERVICES OR HEALTH

Two variations on the question of who should be charged with the responsibility for Homes for Special Care arose on a number of occasions during our deliberations. One aspect of this discussion was the municipal-provincial relationship, in which it was strongly advocated that the Province assume total financial responsibility for Homes. This subject was discussed in Section 8.1, Provincial-Municipal Relationships. Here we are addressing briefly the subject of auspices, in terms of which department of government should be charged with the responsibility for Homes for Special Care.

Nursing or Level II care, which was deemed to be more Health than Social Services oriented, was frequently viewed as an area which would be more suitably placed under the aegis of the Department of Health.

Several municipalities, Homes for Special Care and private organizations suggested that either all Homes for Special Care or the nursing care component only be transferred to the Department of Health. Although they reached the same conclusion, each group arrived at it from a slightly different direction. The following points summarize the reasons given in support of a change of auspices:

- The current system is inequitable in that it penalizes those people who have been most productive throughout their lives, at a time when they are most vulnerable, by forcing them to deplete their life savings. The Health system, on the other hand, is accredited with the ability to provide the required service on a universally insured basis

- The transfer to the Department of Health would alleviate the differences, gaps and overlaps experienced in services, policies and funding which occur between the Health and Social Service systems

and impedes the smooth flow of residents back and forth between the two systems

- Care requirements are perceived by the administrators of Homes, in particular, as having increased in the last two or three years to a point beyond that which can be provided in Nursing Homes and Homes for the Aged, given current funding and staffing guidelines. Health once again is seen as having more potential in terms of meeting the increasing care and funding requirements.

- The uncertainty of government funding policies for Homes for Special Care may place municipalities in the position of having to assume a greater proportion of the costs. It is assumed a more stabilized, consistent funding base will be provided under the Department of Health.

Senior citizens' organizations which presented briefs were divided on the question of where the responsibility for Homes should rest - Health or Social Services. Of major concern to one large consumer group was the establishment and maintenance of a home like environment for elderly persons who must enter Homes for Special Care. "Mini-hospitals", based on a regimented medical model, give little attention to individual and personal differences in life style and were not regarded as desirable for most elderly persons whose care needs cannot be met in the community.

Universality would alleviate financial inequities in the system at considerable additional cost to the Province or municipalities. Universally insured services and other financial alternatives are discussed in Part 7 of the report and include the assumption that the municipalities will continue to maintain persons in need in Homes for Special Care.

A transfer to Health presupposes all Nursing Homes and Homes for the Aged would be moved. To transfer Level II nursing care, as many suggested, would only alleviate some of the problems. Residents of Homes for the Aged would still have to move back and forth between the two systems. In addition, if Level II care under Health became insured and Level I care remained on a needs tested basis under the Department of Social Services, inequities would continue to exist.

During the course of the Task Group's work, an assessment was undertaken of the levels of care required by residents in all Nursing Homes. Fifty-seven residents were found to require Level III or extended care which falls under the responsibility of the Department of Health. The perception of an increasingly heavier care need for the majority of residents was found to be accurate. When Homes were established in the 1960's and 1970's one-third of the beds were designated for nursing care and two-thirds were for light care. Over the years this situation has now reversed itself. It was noted during the assessments, however, that even though the majority of residents require more care, the nature of the care need is such that it can be met by staff other than registered nurses.

There is no evidence that a change of auspices would increase the quality of care provided in Homes for Special Care. The changes suggested would simply lead to a reallocation of dollars and costs. They highlight the dilemma which faces all levels of government, and one with which the Task Group struggled: how to rationalize the care system, close the gaps in service, meet individual needs, diminish the problems that arise when two large human service systems, Health and Social Services, are involved, without substantially increasing costs. Within this context there are no simple solutions, regardless of which department of government is responsible for the service delivery system. The recommendations of the Task Group and Working Groups are, therefore, directed toward making those immediate changes which can be implemented within the current economic milieu, and which will alleviate or overcome some of the difficulties being experienced. Additional

recommendations have also been made which the Task Group hopes will be viewed as initiating the search for longer term solutions.

8.3 DECENTRALIZATION, CO-ORDINATION, REGIONALIZATION

Decentralization, co-ordination, regionalization; these three words occurred frequently in conversations, briefs, reports of Working Groups and discussions to which members of the Task Group were privy. They were used to describe the ideal or most desirable options for the structuring of services and programs, and for problem resolution. Often, although distinct in meaning, they were presented as one concept. The following brief comments provide a synopsis of the general views of the Task Group in each area.

DECENTRALIZATION

To the Task Group, decentralization implies the relocation to regional and district offices of functions now located and managed centrally in the Head Office of the Department of Social Services. It was mentioned more frequently than either co-ordination or regionalization. In emphasizing the necessity for, and advantages of decentralization, the presenters commented upon the need for services and programs to be close to referral sources and those for whom they were designed; to be sensitive and responsive to local differences; and to respond quickly to individual needs. Most often the area of classifications and assessments was viewed as being of most pressing concern in relation to decentralization.

The Department of Social Services has already committed itself to decentralization. In some programs, such as Child Welfare, there has traditionally been decentralization, while in others, such as Family Benefits, decentralization is just beginning. Although in agreement with the basic principle of decentralization, the Task Group views it as an integral part of the overall design of regional planning and responsibility for service delivery, and not as a principle to be implemented in isolation. We therefore raise the following cautionary points:

- Not all functions lend themselves to decentralization or should be decentralized. For example, after careful examination the Task Group decided that the per diem rate-setting function was far more easily and consistently managed centrally.

- Decentralization has costs attached to it since the number of skilled staff would need to be increased in order to carry out similar functions in several areas.

- Unless decentralization was carefully planned and executed, inconsistencies could occur causing province-wide standards of quality to deteriorate.

- Decentralization will not solve the three problems which were most often linked to it: lack of co-operation between professional service providers; what the Task Group perceived as lack of understanding by social services and health professionals of each others service systems; and the division of responsibilities between the various levels of government. These matters can only be remedied by better communication and increased understanding between professionals in the social services and health sectors.

Other parts of this report have addressed specific areas where decentralization would be effective, and where, with careful planning and implementation as part of an overall plan for change, appropriate decentralization should proceed.

CO-ORDINATION

The subject of co-ordination was raised in twenty-three of the briefs presented to the Task Group and even more frequently during discussions. Co-ordination of community services, particularly those commonly associated with a Home Care Program, was considered of vital importance in keeping people in their communities longer thereby avoiding or delaying institutionalization.

DECENTRALIZATION, CO-ORDINATION, REGIONALIZATION

Some of the Working Groups saw co-ordination as part of an overall regional planning mechanism which would address the problem of duplication of services, provide for a better use of scarce dollars and service resources, and lead to rationalization of the structure of the service system.

The Task Group considers co-ordination extremely desirable, both for those reasons already cited, and for the individual client or prospective resident who must try to decipher which services are available where and on what basis. Fortunately, a fairly informal, local co-ordination process often occurs because the professionals involved, who represent various parts of the human service sector, know each other.

In the broader area of the development and planning of service systems, co-ordination has been an elusive goal . In fact, the Task Group believes that other than on an individual, client-related, local level, a significant degree of co-ordination will not be achieved until our service delivery system is restructured.

REGIONALIZATION

The concept of regionalization was addressed throughout our deliberations from three perspectives:

- The development of a management system on a regional basis within the Department of Social Services. In this system responsibility for planning, co-ordination and management of programs and services would rest with the regional administrator. Decentralization of programs and services is assumed to be part of this scenario.

- The establishment of a county-based planning and management structure for specific service areas - for example, services to mentally handicapped adults.

- The formation of new regional structures which would have a larger geographical basis for the planning, funding and management of Homes for Special Care and for delivering services such as homemaker programs.

The Working Groups on Classifications and Assessments, Services to Mentally Handicapped Adults and Financing discussed regionalization and made relevant recommendations. Although the recommendations differed slightly in all three reports, regionalization was seen as a way to bring some order into the service system, to avoid duplication of services and facilities, to identify gaps in services and programs, to project service needs and better utilize the scarce dollars available.

The Department of Social Services has already started strengthening and increasing its regional management system for services and programs. That in itself is a progressive move and when complete, could facilitate the development of a broader regional management approach - if a decision were to be made to proceed in that direction.

The possibility of regionalizing planning and management functions in the area of Homes for Special Care was discussed when the Task Group met with representatives of the municipal units. The advantages of this arrangement were clearly pointed out, and included:

- improved co-ordination on a regional basis of such things as personnel policies, purchasing and financial management

- planning for future service needs on a regional basis so that a new Home or expansion of an existing Home would not proceed unless beds were required within the region. In the past such growth in one community has had a detrimental financial effect on existing facilities in other communities in the same region

- improved co-operation between municipal units and non-profit homes

- the sharing of resources

- the possibility of cost savings or better use of existing municipal/provincial funds.

Most of the representatives of municipalities were in general agreement with the advantages of regionalization but were reluctant to make a commitment to move beyond that point. The concept appeared to be acceptable as long as individuals could be served in facilities in their own home communities and local control would remain unaltered.

Regionalization is a very complex issue with far reaching effects on, and implications for, both municipal governments and the provincial government. The Graham Royal Commission[1] spent considerable time and effort studying regional government, and although the concept and approach discussed here is not nearly as dramatic or extensive as the changes Graham suggested, it is nevertheless far different than that which presently exists. Re-organization on a regional basis will mean fundamental changes in municipal structures and the manner in which the Province relates to them.

The Task Group supports an attempt to examine the possibilities of establishing a regional approach and has adopted the recommendation of the Working Group on Financing that:

8.3.1 A Joint Provincial Municipal Study Group should be formed to review and assess the feasibility of establishing a regional approach to the development, administration and funding of programs related to Homes for Special Care and related community services.

8.4 LEGISLATION

Throughout the Task Group Report it is noted that for the most part recommendations would require changes to policies or procedures. If adopted, some recommendations would result in immediate changes in the Homes for Special Care Act and Regulations.

The Homes for Special Care Act, which was given Royal Assent in May 1976, was an amalgamation of the Nursing Homes Act, Boarding Homes Act and sections of Part II of the Social Assistance Act. The Regulations pursuant to the Act came into effect in September 1977. Although there have been amendments since 1977, there has been no complete review of the Homes for Special Care Act and Regulations. They require substantial changes to increase clarity and ease of administration.

8.4.1 The Task Group recommends an overall review and updating of the Homes for Special Care Act and Regulations and an examination of related legislation in terms of compatability.

8.5 HOME CARE

The recommendation which was made most often in the 102 briefs submitted to the Task Group was for the establishment of a co-ordinated home care program which would present a viable alternative to institutionalization.

Recognizing the need to develop in-home supports for senior citizens, disabled persons and families in crisis, the Department of Social Services began providing funding in 1978 to agencies and municipalities to develop homemaker services. Today there are 41 homemaker service programs operating with a clientele of approximately 2200. Eighty percent of the clientele of Homemaker Services Agencies are senior citizens. The homemakers are providing services for these people which help maintain them at home and thereby delay or avoid institutionalization altogether.

Recently the Province has taken another step in developing in-home support services by introducing a Home Life Supports Program. The objective of the program is to assist senior citizens and disabled persons to remain in their own homes. The Department of Social Services has been given the responsibility of co-ordinating government programs to meet that objective.

There are several components to the Home Life Supports Program. The traditional Homemakers Services Program will be expanded to include additional services and will constitute one part of the new comprehensive Home Life Supports Program. A provincial demonstration fund has been established to encourage and foster local creative and innovative self-help, community, intergenerational, volunteer efforts. In addition, a cost-sharing program with municipalities for the provision of in-home support services has been inaugurated. The health care component, (such as home nursing services) which must be part of a comprehensive Home Life Supports Program, will continue under the auspices of the Department of Health.

The Task Group carefully examined Home Care programs in other provinces, particularly those offered in Manitoba and Alberta. In both those provinces Home Care is one component of a comprehensive, co-ordinated system of continuing care. It is a universally insured service provided as an alternative to institutional care.

A common criterion for entry into the Home Care Program, whether in Alberta or Manitoba, is that the cost of maintaining a person in their own home must not exceed the cost of maintaining that person in a nursing home. In Manitoba admission to the system can be on social or medical need or a combination of both. In the application process an assessment panel comprised of a physician, nurse and social worker determine the capabilities of the applicant before making the decision regarding the relative appropriateness of Home Care and residential care. The assessment also identifies which activities can realistically be performed by other members of the household or relatives living within a reasonable distance. Resources which exist in the community or through other government programs, are also considered.

In Alberta, the criterion for entry into the system is medical. A physician certifies that a person under his care is in need of a home care nursing or rehabilitation therapy service. This was reported to be a major weakness in the system, and consumers recommended that social factors should be included in entry prerequisites to Home Care. In accordance with Manitoba, the Province of Alberta requires that the client and family must want the service to be provided in their home. The home must also be in an appropriate setting so that the care can be provided in a safe and effective manner.

It is interesting to note that the availability of Home Care in these provinces has neither lowered the number of beds being utilized nor decreased the demand for beds. The percentage increase in the expenditures for Home Care from one year to another has no apparent impact on the percentage increase for Homes for Special

Care. For example, in Manitoba expenditures for Home Care between the 1980/82 fiscal years increased by 21 percent and the expenditures for Homes for Special Care increased by 23 percent. Similarly in Alberta for the same fiscal period expenditures for Home Care increased by 13 percent and those for Homes for Special Care increased by 29 percent. With a population of just over two million, Alberta spent approximately $18.1 million on Home Care in 1983-84 while Manitoba with a population of slightly over one million spent approximately $18.6 million for the same period.

It is evident that immediate cost savings are not realized in Homes for Special Care expenditures with the initiation of a Home Care Program. In fact, a duality of costs occur. On a longer term basis, however, a Home Care Program should decrease the need to provide beds thus effecting a cost saving.

The most persuasive arguments for Home Care are the alternatives it offers to residential care and the enhancement of the quality of life it provides for the elderly and disabled persons. For those persons who can remain in and receive care in the familiar surroundings of home and family, the trauma of a move to an institution is avoided.

Although Home Care is expensive, the Province has already taken a number of steps along the way to a total Home Care Program. Recognizing this and the need for continued growth in this direction the Task Group recommend that:

8.5.1 The Department of Social Services continue to expand its Home Life Supports Program, thus enhancing the quality of life for the elderly and disabled by providing an alternative to institutional care.

8.6 HOMES AND THE PROVISION OF SUPPORTIVE SERVICES FOR SENIORS LIVING IN THE COMMUNITY

Two major areas in which Homes for Special Care can be supportive of seniors living in the community are through respite and senior day care programs.

Respite care provided by Nursing Homes and Homes for the Aged is governed by the policies of each individual Home. Although the Department of Social Services does have an established set of guidelines for respite care, no distinction is made between respite beds and regular beds. Most homes have a policy that respite care will not be provided to a resident on a continuous basis for more than 30 days.

Generally, municipally operated Homes have a formal procedure for respite placement which is the same as the placement of a resident for long-term care and includes the classification of the individual. This procedure is also applied in the respite placement of a person who is publicly supported in a private facility. For private paying residents there is a verbal or written contract between the home and the applicant.

The policy on respite care in Community Residences for the Mentally Handicapped is distinct from that in other Homes. The policy guidelines on placement require authorization of the Department of Social Services and the classification procedure is the same as that used for the normal placement in a Home for Special Care. A suitable day program must be available to the respite resident prior to admission.

Senior Day Care in Nova Scotia is a developing service. Recently, there have been efforts made by individual Homes to begin a Senior Day Care Program; however, there has not been a concerted attempt to make such a program an integral component of their services. Two adjustments that have to be made to get the program underway are the provision of suitable transportation from the

seniors' homes to the facility and flexible staff hours required by the Home in order to accommodate the schedule of seniors.

The Province of Manitoba offers one model currently in use for respite care and day care. Both are components of their Continuing Care Program. The primary objective of Adult Day Care is to strengthen the individual's ability to function within his own home or community and to prevent the deterioration of physical and mental health functions. Adult Day Care also provides relief to the family and community support system. A Home offering this service must have a minimum program combination which includes provision of safe and reliable transporation, recreation and socialization, a nutritious mid-day meal and snacks, and the use of volunteers in the delivery of service or enrichment of the program. Usually these programs operate two days a week for six hours per day.

The application process for Adult Day Care includes an assessment of the need for the program by Continuing Care Co-ordinators from the Department of Health and Community Services. Funding is the responsibility of the Manitoba Health Services Commission.

Respite care, as a component of Manitoba's Continuing Care Program, is the most appropriate means of providing a period of relief to the family as well as providing the care and supervision required by the client. In the admission procedure the Continuing Care Co-ordinator must determine the eligibility and appropriateness of the placement and recommend the respite care as the most appropriate service. A contract is prepared between the family and the facility for a specified period. Respite care is part of an insured Home Care Program. The facility itself is responsible for maintaining appropriate records on the individual which includes plan of care, progress notes, medication orders and records.

Six briefs presented to the Task Group were supportive of respite care. The Associated Homes for Special Care recommended the use of Homes for Special

Care to support community home care by providing such programs as Meals-on-Wheels, Meals-to-Wheels, Home Help, Daily Hello and Day Care. According to the Association, several Homes in Nova Scotia have instituted meal delivery programs, home help and other programs with the co-ordinator housed in their facilities.

The Task Group believes that Homes should be an integral part of a total support system for the disabled and senior citizens living in the community. They represent established organizations in the community with experienced administrative and program staff already in place. With minimal adjustments most Homes can offer a variety of programs and services directed toward maintaining seniors and the disabled in their own homes. The Task Group recommends that:

8.6.1 Homes for Special Care be encouraged to develop and provide services to senior citizens and the disabled persons living in their own homes.

8.7 INFORMATION

The majority of the people with whom the Task Group met spoke of the need for more information on:

- services and programs of the Department of Social Services;
- the rights of residents in Homes for Special Care;
- the appeal mechanisms in place related to Homes
- the Department's expectations regarding such things as licensing and inspections.

Although the Department of Social Services has made an effort to provide information both written and verbally, the perception of the presenters was that there is little information available. The Department must therefore make a concerted effort to provide more information on Homes for Special Care to the public, Homes for Special Care and Municipalities.

Perhaps it should be clarified that the need for guidelines on specific areas of concern has been addressed many times throughout this report. In this instance it is the need for public information (including information for residents) which is under discussion.

The Task Group considers that the dissemination of information is an important element in increasing understanding and knowledge of the Homes for Special Care system. In recent months, in conjunction with the Associated Homes for Special Care, the Department of Social Services produced an information pamphlet for residents of Homes for Special Care and their families. This was a very successful endeavour and could provide a model for future development of public information materials.

8.8 TERMINOLOGY

The names Nursing Home and Homes for the Aged cause innumerable difficulties and confusion. People perceive Nursing Homes as facilities where bona fide nursing care is provided while Homes for the Aged are viewed as providing a lesser level of care. In fact both groups of Homes serve the same population and both offer Level I and Level II care. The Task Group recommends:

8.8.1. That the Department of Social Services develop common descriptive terminology for Nursing Homes and Homes for the Aged.

Further, the Task Group suggests that in arriving at a suitable name for these facilities the word "nursing" be avoided because it is misleading.

8.9 ACCREDITATION

In Nova Scotia accreditation is generally viewed as an expensive process which is oriented toward a hospital medical model, not Homes for Special Care. In this context accreditation was discussed by the Task Group with operators of facilities (in other provinces and in Nova Scotia), professional and health organizations, representatives of Homes for Special Care, and the Working Group on Standards of Care. There were a wide variety of opinions on the usefulness of accreditation in ensuring a certain standard and quality of care in Homes for Special Care.

It is the Task Group's understanding that overall there is an interest in making accreditation more meaningful and more applicable to Homes for Special Care. Although the Task Group is not recommending that accreditation be mandatory at this time, it is suggested the Department of Social Services examine this issue again within the next few years.

8.10 THE CONSUMER

Throughout this report mention is made of the contributions consumers and consumer organizations made to the Task Group's work. Their comments, suggestions and recommendations provided valuable insight, and enhanced the Task Group's understanding of the problems and concerns of residents of Homes for Special Care.

The Task Group believes that the consumer perspective can be an invaluable component in examining, planning and developing programs, services and facilities, and that consumer participation in these processes should be encouraged whenever possible.

FOOTNOTES

FOOTNOTES

HISTORICAL OVERVIEW

1. Contents are based on a "History of Homes for Special Care, 1759 -1983" prepared for the Task Group by Robert G. Haley, Chief Instructor, Social Service Training Programs, Department of Social Services. Excluded from this overview, except for brief mention, is the development of services for mentally handicapped children and vocational services for the adult mentally handicapped.

STANDARDS OF CARE

1. Refer to Regulations made Pursuant to Section 22(1), Chapter 12 of the Statutes of Nova Scotia, 1976 - The Homes for Special Care Act. Section 18, subsections (1), (2), and (3).

2. Task Force Reports on the Cost of Health Services in Canada - Utilization Operational Efficiency, Salaries and Wages, Bed and Utilization. Prepared by the Working Part on Patient Care Classification. Federal/Provincial Advisory Committee on Health Insurance, Department of National Health and Welfare, November, 1973. See pgs. 270, 271, 307-311 inclusive.

3. The conventionial system utilizes oxygen cylinders and the cost would be as follows:

   Kit which includes the mask, regulator, humidifier and nostril tube can be purchased for approximately $158.

   Cylinders are rented to the client. The rental charge is $8 per month or $53 per year. Large cylinders hold 244 cu. ft. of gas. Consumption, at the normal setting, is approximately 4. cu. ft. per hour. At this rate a client on continuous oxygen would use approximately 12 cylinders per month. Cost of the gas, per fill up, is $22 which would translate into $264 per month.

   The oxygen concentrator eliminates the tank system by utilizing and concentrating room air. The system is operated by electricity, therefore a back-up tank is required in the event of a power failure.

   The cost of a single oxygen concentrator is approximately $3200. A double concentrator which can be used by two people simultaneously would be more expensive.

DECENTRALIZATION, COORDINATION, REGIONALIZATION

1. The Royal Commission on Education, Public Services and Provincial/Municipal Relations, 1974 Chaired by Dr. John Graham.

RESIDENTIAL CARE FACILITIES

1. The Homes for Special Care Act, Chapter 12, Statutes of Nova Scotia, 1976.

   The Homes for Special Care Regulations, enacted September 1977 as amended.

2. Statistics quoted are based on May 1, 1984 figures.

3. The Task Group has taken the liberty of consolidating, enhancing or adding to the recommendations of the Working Groups as required. As well, where conflicts existed between Working Groups this has been noted and clarified.

APPENDIX A

TERMS OF REFERENCE

APPENDIX A

TERMS OF REFERENCE

STUDY OF NURSING HOMES, HOMES FOR THE AGED

AND RESIDENTIAL CARE FACILITIES

The study would be undertaken within the context of two assumptions —

(1) the Department of Social Services, through the Homes for Special Care Act and Regulations, will continue to require owners and administrators to ensure that residents in Nursing Homes, Homes for the Aged and Residential Care Facilities, regardless of their auspices, receive quality care; and

(2) that government maintain but not substantially increase its level of support to Municipalities, who are and will continue to be required by law to maintain persons in need in such Homes.

The mandate of the Task Group, generally stated, would be to review all aspects of Nursing Homes, Homes for the Aged and Residential Care Facilities for the purpose of —

(1) recommending necessary bed requirements for the next six years including numbers and locations;

(2) identifying problem areas related to legislation, regulations, policies, guidelines and procedures;

(3) proposing options for the resolution of these problem areas;

(4) determining the cost implications.

In carrying out this task, it will be essential for the Task Group to bear in mind both the institutional and non-institutional programs for seniors now in place or prospective and the interface among them.

While not limiting the generality of the above, it is desired that the Task Group will address the following areas:

(1) <u>Bed Requirements</u>

- the adequacy of present process and guidelines for establishing bed requirements throughout the Province;

- the number and location of bed requirements for each of the next six years, and the mix as between levels of care;

- the appropriate mix of private versus publicly-supported beds; and,

- the role of the profit/non-profit sectors in responding to identified bed requirements.

(2) Standards of Care

- the adequacy of current staff guidelines - should we maintain our current practice of defining minimum and optimum requirements? do we adequately address the question of staff qualifications? is the system in place for determining salary levels the appropriate system? should there be maximum levels beyond which cost-sharing would decline or end?

- the adequacy of our current requirements respecting the design, construction and furnishing of Homes for Special Care, including such areas as -- are homes designed and furnished in a manner which maximizes the safety and comfort of residents while at the same time ensuring the optimal degree of privacy, freedom and involvement?; what are the optimal and minimal designs and sizes of homes?; are homes designed to facilitate with minimal additional expense, changing requirements from light to heavy care?; are homes designed to provide appropriate care for couples?; what provision should be made for short-term respite care?;

- the nature and type of programs and activities required or desirable in such homes to maximize the self-fullfilment and dignity of residents and to encourage their participation in their care to the fullest extent possible;

- the rights and responsibilities of residents and the extent to which they are promulgated, understood and enforced;

- the role of volunteerism and community effort in support of residents in Homes for Special Care;

- ways and means of fostering and encouraging inter-generational relations involving the residents of the homes;

- the nature and extent to which homes can be supportive of seniors living in the community;

- the provision of pastoral care in homes.

(3) Financing

- the most appropriate method of financing such homes given financial realities, including the resident contribution and how it should be determined, the role of the municipal level of government, and the role of the Province;

- role, composition and operation of the Rate Setting Committee;

- optional approaches and mechanisms for establishing per diem rates, the advantages and disadvantages of each;

- the factors to be considered in establishing per diem rates and the extent to which these are adequately and appropriately covered under the present rate-setting guidelines;

- the advantages and disadvantages of a one rate versus two rate system;

- the advantages and disadvantages of block-funding support to municipalities.

(4) Classifications and Assessments

- the appropriate role, composition and operation of the Classification Committee, including whether or not the Department should retain a centralized or move to a decentralized operation;

- the appropriate role, composition and operation of the local Assessment Committees, including whether or not this should remain a Health or become a Social Services responsibility.

APPENDIX A

TERMS OF REFERENCE

FOR WORKING GROUP(S) ON

PROGRAMS FOR THE MENTALLY HANDICAPPED

Within the limits of the Department's mandate, as defined in legislation, and given that the Department will maintain but not substantially increase its level of support to services for the mentally handicapped over the next six years, to review all aspects of the current program as provided by the Municipal and Provincial levels of government and the private sector for the purpose of identifying, quantifying and costing, in order of priority, at the regional and Provincial levels, the essential requiremments of a program for the mentally handicapped (children and adults) which maximize their potential for leading a normal, independent and productive life. Specific attention should be made in identifying the requirements to flow out the order in which they should be developed.

While not limiting the generalities of this mandate, it is desired that the working group(s) will address the following areas:

- identifying, on a regional and Provincial basis, the current and projected numbers of mentally handicapped children and adults requiring services on a yearly basis for each of the next six years;

- the adequacy of our present system of determining the service requirements and options for improving this system;

- the nature, type and mix of services required on a regional and Provincial basis, including but not limited to, such areas as income, housing, employment, rehabilitation and community support services;

- the appropriate role and responsibility of the mentally handicapped, parents and families, volunteers, the private sector, Municipal and Provincial levels of government, in the provision of required services;

- the appropriate role, composition and operation of the Classification Committee, including whether or not the Department should retain a central or move to a decentralized operation;

- the appropriate role, composition and operation of the local Assessment Committees;

- the adequacy of the present appeal provisions.

In carrying out the mandate, it is anticipated that two working groups will be

required — one focusing on the mentally retarded children and the other on the mentally handicapped adults.

In addition to reviewing programs within the Province, it is expected that the working group(s) will review programs developed in other Provinces and the latest thinking in the literature respecting philosophies, modabilities and ways and means of organizing and delivering services to maximize the potential of the mentally handicapped.

Because of the foreseeable realities with respect to funding, special emphasis should be placed on ways and means of revamping the re-allocating current service components and dollars to maximize their impact on assisting the mentally handicapped to realize their full potential.

The working group(s) will report and be responsible to the Task Group on Homes for Special Care chaired by Miss Bessie Harris. Working groups will commence their assignments in April and will submit their reports in accordance with a timetable developed by each Working Group in conjunction with the Task Group.

APPENDIX A

TERMS OF REFERENCE

COMFORTS ALLOWANCE*

The examination of Comforts Allowance is to determine:

1. the adequacy of the current comforts allowance;

2. whether or not comforts allowance should be increased on a regular basis by some indicator such as the cost of living.

As well the sub-committe is directed to explore the feasibility of the Department of Social Services paying comforts allowance to residents in Homes for Special Care through its Family Benefits program. In doing so the matter of continued Federal cost-sharing or the possible requirements for legislative change should be reviewed.

* Based on a memorandum from John A. MacKenzie dated June 28, 1983 to the Chairperson of the Task Group.

APPENDIX B

MEMBERS OF THE TASK GROUP AND WORKING GROUPS

APPENDIX B

MEMBERSHIP OF THE TASK GROUP

Bessie Harris, Chairperson	Department of Social Services
Michael Craig, Secretary	Department of Social Services
James A. MacIsaac	Department of Social Services
James A.A. MacKinnon	Department of Social Services
Peter Barteaux	Department of Social Services
Gwen Pickering (Ex Officio)	Department of Social Services

Working Group on Bed Requirements

Elizabeth McNaughton, Chairperson	Department of Social Services
Shulamith Medjuck	Department of Social Services
Michael Johnston	Department of Social Services
Joan Snow	Department of Social Services
Virginia MacDonald	Department of Health

Working Group on Classifications & Assessments

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Barbara Carbonell	Department of Social Services
Malcolm MacFarlane	Department of Social Services
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Dane Percy	Department of Social Services

Working Group on Comforts Allowance

Shulamith Medjuck, Chairperson	Department of Social Services
Edward Roach	Halifax Senior Citizens Housing Corporation Limited
Harold Crowell	City of Halifax
Allison Hartlen	Department of Social Services
Helena Poirier	Union of Nova Scotia Municipalities
Sheldon Langille	Associated Homes for Special Care

Working Group on Financing

James A.A. MacKinnon, Co-Chairperson	Department of Social Services
Peter Barteaux, Co-Chairperson	Department of Social Services

Working Group on Financing
(Continued)

Bessie Harris	Department of Social Services
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Working Group on Services to Mentally Handicapped Adults

Ross Thorpe, Chairperson	Department of Social Services
George Matthews	Department of Social Services
Andre McConnell	Department of Social Services
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Working Group on Services to Mentally Handicapped Children

John Walker, Chairperson	Department of Social Services
Grace Beuree	Department of Education
Doreen McClelland	Department of Social Services
Joan MacKinnon	Department of Social Services
Bill McCarron	Department of Social Services

Working Group on Standards of Care

Barb Millar, Chairperson	Department of Social Services
Sheldon Langille	Associated Homes for Special Care

Working Group on Standards of Care
Continued

John Morrison	Associated Homes for Special Care
Jack Haley	Nova Scotia Federation of Labour
Janet Bray	Department of Social Services

APPENDIX C

BRIEFS

BRIEFS

A letter announcing the Task Force and introducing the Terms of Reference were sent to organizations, Homes for Special Care, and municipalities who were given the opportunity to meet with the Task Group and share their concerns and ideas. A newspaper advertisement invited written presentations from the public. As a result 48 individual Nova Scotians replied.

The following is a list of the briefs received. Letters from individuals have not been included in the listing.

Alderwood Rest Home

Town of Amherst

Annapolis Royal Nursing Home Limited

County of Antigonish

Town of Antigonish

Associated Homes for Special Care (Nova Scotia)

Associated Homes for Special Care (South Shore Region)

Associated Homes for Special Care (Cape Breton Region)

Association of Psychologists of Nova Scotia

Avonview Rest Home

Bide-A-While Shelter Society

Bonny Lea Farm

Town of Bridgewater

Camp Hill Hospital

Canada Mortgage and Housing Corporation

Canadian Association for the Mentally Retarded

Canadian Mental Health Association (N.S. Division)

Canadian Pensioners Concerned Incorporated

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Canadian Physiotherapy Association, N.S. Branch

Canadian Red Cross Homemakers (N.S. Division)

Town of Canso

Cape Breton Pensioners Concerned

Municipality of the District of Chester

Citizens Service League

Municipality of the District of Clare

Colchester Association for Mentally Retarded (McCully House)

Colchester Hospital

Municipality of the County of Colchester

Community Housing for the Emotionally Handicapped (Union St. Group Home)

Community Living Alternatives Society

Municipality of Cumberland County

Dartmouth General Hospital and Community Health Care Centre

Disabled Consumers Society of Colchester

Disabled Individuals Alliance

Edward Mortimer Place/Town of Pictou

Extendicare Limited

Municipality of the District of Guysborough

City of Halifax

Municipality of the County of Halifax

Halifax County Regional Rehabilitation Centre

Halifax Senior Citizens' Housing Corporation Limited

Municipal Units of Hants County

Highland Community Residential Services

Highland Rest Home

Homes for Independent Living/Canadian Paraplegic Association, Nova Scotia Division

Hospital Social Work Departments of Central Region

Institute of Pastoral Training

Municipality of the County of Inverness/Municipal Housing Corporation

Town of Kentville

Municipality of the County of Kings

Kings Regional Health & Rehabilitation Centre

LaHave Manor Adult Residential Centre

Town of Lockeport

Municipality of the District of Lunenburg

Town of Lunenburg

Mahone Nursing Home

Maple Hill Manor

Medical Society of Nova Scotia

Medicus Canada

Metropolitan Group Homes Association

Metropolitan Mental Health Planning Board

Town of Mulgrave

New Dawn Guest Home

Town of New Glasgow

New Waterford Homemaker Service Society

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North Queens Nursing Home

Nova Scotia Association of Health Organizations

Nova Scotia Association of Social Workers

Nova Scotia Certified Nursing Assistant Association

Nova Scotia Commission on Drug Dependency

Nova Scotia Dental Association

Nova Scotia Dietetic Association

Nova Scotia Hospital - Social Services

Nova Scotia Hospital - Psychiatry

Nova Scotia Human Rights Commission

Nova Scotia Pharmaceutical Society

Nova Scotia Society of Occupational Therapists

Ocean View Manor

Old Ladies Home Society (Sunset Terrace)

Queens Manor Corporation/Municipaltity of the County of Queens

Recreation Council for the Disabled in Nova Scotia

Regional Residential Services Society

Registered Nurses Association of Nova Scotia

Resi-Care Cape Breton Association

Municipality of the County of Richmond

Scotia Nursing Home Limited

Seaview Manor Corporation

Municipality of the District of Shelburne/Town of Shelburne/Roseway Manor Incorporated Board

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Shoreham Village Senior Citizens Association

Municipality of the District of St. Mary's

Sunset Adult Residential Centre

City of Sydney

Town of Truro

Twin Oaks Senior Citizens Association/The Birches

Union of Nova Scotia Municipalities

Victorian Order of Nurses for Nova Scotia

Villa Acadienne

Villacentres Health Care Services

Municipality of Yarmouth

APPENDIX D

REGIONAL MEETINGS

APPENDIX D

REGIONAL MEETINGS

Bridgewater, N.S. August 29-30, 1983	10 Briefs
Yarmouth, N.S. August 31, 1983	5 Briefs
Kentville, N.S. September 7-8 1983	6 Briefs
Halifax, N.S. September 14-15, 1983	11 Briefs
Sydney, N.S. September 19, 1983	6 Briefs
Baddeck, N.S. September 20, 1983	2 Briefs
Port Hawkesbury, N.S. September 20, 1983	1 Brief
Antigonish, N.S. September 26, 1983	7 Briefs
Amherst, N.S. September 27, 1983	3 Briefs
New Glasgow, N.S. September 27, 1983	1 Brief
Truro, N.S. October 5, 1983	2 Briefs
Halifax, N.S. October 19, 1983	12 Briefs

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